Application of EMDR Therapy to Self-Harming Behaviors

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Self-harm is frequently a trauma-driven coping strategy that can be understood from the perspective of the adaptive information processing (AIP) model and treated with eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 1995, 2001). Self-harm is often connected with memories of adverse and traumatic life experiences. Identifying and processing these memories with EMDR therapy can put an end to the self-injurious behavior. In addition, self-harm is often based on a lack of regulation skills, and these skill deficits can be addressed in EMDR therapy as well. In this article, the authors describe strategies for treating self-harm throughout the 8 phases of EMDR. Although there is no single approach that applies to all cases, the therapist needs to take a careful history of self-harm, its historical origins, and its triggers and functions in the present to formulate a treatment plan. Often, in the authors' experience, self-harm functions as a self-soothing strategy that redissociates traumatic affect from childhood. Treatment strategies for Phases 3–8 of EMDR therapy are illustrated through case vignettes.

Keywords: eye movement desensitization and reprocessing (EMDR); self-harm; dissociation; complex trauma

Of all the complex situations that we might encounter in the therapy setting, self-harm and suicidal ideation are two aspects that present great challenges for a therapist. Self-harm is defined here as intentional physical self-injury without an intent to die, which includes various methods such as cutting, burning (cigarettes, lighters, etc.), scratching, beating oneself up (head-butts, punches), biting, interfering with wound healing, and reckless sex and eating to be sick. The purpose of this article is to describe self-harm as a trauma-driven coping strategy that can be understood from the perspective of the adaptive information processing (AIP) model and that then can be treated with eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 1995, 2001). The AIP model is the theoretical model for EMDR therapy proposed by Shapiro (2001). It was developed to guide history taking, case conceptualization, treatment planning, and interventions and to predict treatment outcome. According to Linehan's (1993) biopsychosocial theory, a formulation that is directly relevant to EMDR therapy, negative emotions contribute to chronic self-harm in borderline personality disorder (BPD) in three ways: (a) The reduction of emotional arousal following self-harm negatively reinforces the behavior; (b) anger, contempt, and shame interfere with healthy problem solving and emotional processing; and (c) shame-related emotions directly lead to self-punishment, or an extreme desire to hide or disappear (i.e., lose consciousness or die). Negative emotions, in the authors' view, often, but not always, arise from unresolved traumatic experiences.

When self-destructive behaviors are based on a lack of regulation skills, it is necessary for the client to learn adaptive coping skills and tools. In our experience, reprocessing memories that are at the basis of such dysregulation will be crucial in many cases, especially when emotions, feelings, beliefs, or self-harm behaviors are connected to specific traumatic memories and dysfunctionally stored information (Mosquera & Gonzalez, 2014). In this article, we will describe how to explore, identify, and treat different types of self-destructive behaviors in the different phases of EMDR therapy.

EMDR Phase 1: History

One of the main issues that can interfere with an adequate case conceptualization is lack of information

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about self-harming behaviors. Sometimes, clinicians have difficulty exploring these aspects of the client's behavior because they think the client will become unstable if they do so. This is actually a misconception; only by exploring these behaviors can the clinician obtain a comprehensive understanding of the client's issues. By understanding the function of self-harm and how it is helping each client, clinicians will be able to design an adequate treatment plan.

Although self-harm behaviors are often labeled as attempts of manipulation or calls for attention, underneath each one of them, there may be very different problems that must be identified (Mosquera & Gonzalez, 2014). Thinking of self-harm behaviors as *manipulation* or *calls for attention* can make them seem like deliberate, conscious blackmail. As is described throughout this article, self-harm has many different motives, of which manipulation and calls for help are only two. Negative moral judgments about self-harm behavior by therapists do not lead to forming a treatment alliance or fostering healthier behavior and coping strategies. To understand this type of behavior by clients, we need to explore the self-harm from the perspective of the client's history. Where was this behavior learned? What is its function? How is it helping the client? What healthier resources are missing from the client's set of coping strategies?

Common motives for self-harm include to feel relief, to "stop the pain," to feel alive or "real," to "show how much I suffer," to ask for help, to get "what I deserve" (self-punishment), to "cleanse myself" (purification), to make sure that "I am not dreaming" (usually related to dissociative experiences), to "feel my body again," and to punish self or others. In addition to the more obvious self-harming behaviors mentioned, many clients use multiple self-destructive behaviors, such as alcohol or drug abuse, risky behaviors such as reckless driving, picking fights, and impulsive sex. Often, clients feel bad about these behaviors and this reinforces the problem because clients self-harm again to get away from their guilt about their previous self-harm. The behaviors are self-reinforcing because they provide temporary relief by dissociating the person from his or her pain and conflicts. However, the dissociation is only temporarily or partially effective; sooner or later, the dissociated memories and feelings intrude again and then have to be redissociated through further self-harm.

Clients who grew up feeling that no one noticed how they felt, or that they were suffering, may desperately need for the other to "see" or "understand." Sometimes, clients try to make their pain "visible" not only for others but also for themselves. Sometimes, after many failed attempts at being noticed, nurtured, or cared about, self-harm is the only way the person finds to ask for help or to get it. Sometimes, self-harm can be a form of self-punishment for occasions on which the person saw himself or herself as aggressive, wrong, bad, or inadequate. Self-harm, in our experience, can be a way to express how guilty a person feels and can be a kind of apology or atonement (Mosquera, 2008; Mosquera & Gonzalez, 2014; Ross & Halpern, 2009).

Examples of such motives we have heard from clients include the following:

> I spent years asking for help directly, but they only began to listen to me when I started to burn and bite my arms.
>
> I was invisible for my family, I could spend days in bed and nobody would notice. I tried to get help many times but they only responded when I pulled my fingernails out, shaved my hair, and cut my body.

Exploration of suicidal ideation, previous suicide attempts, and self-harming behaviors should be included in Phase 1: History Taking. However, this is not always simple in cases of complex trauma and dissociation. The person might not remember the details of what lead up to and motivated a self-harm behavior because of amnesia, or some parts might not want to disclose this information for different reasons.

When self-injury has become habitual, the behavior can become automatic and clients will have difficulty reflecting on the possible triggers, feelings, and thoughts related to the self-harm. It is important to help clients think about possible triggers and get perspective on them. We should always explore what happened immediately before the self-injury and the emotional state related to the behavior. The responses to this exploration will give the therapist relevant information about the resources that need to be installed and the psychoeducation that needs to be introduced in Phase 2 as well as possible targets that need to be addressed after the preparation phase (Mosquera, 2014).

Self-harm should be explored in the first sessions. As commented earlier, clinicians need to understand the underlying issues to create a complete and comprehensive therapeutic plan. Some useful questions for exploring the roots of self-harm, as described by Mosquera (2014), include the following:

- When was the first time you cut, burned, or harmed yourself?
- What was happening then?
- Did others know about the self-harm? If they did, how did they react?
- How did you feel afterward?
- What do you think about yourself right before you self-injure? And after?

- What emotions or feelings are related to this behavior? Anger? Sadness? Emptiness? Shame? Anxiety? Numbness? (The therapist can provide a menu of possible emotions if the client has difficulty identifying the emotional state that preceded the self-harm.)
- In what ways does the self-harm help?

All these questions will help clinicians focus on the self-harming behavior and see beyond the symptoms. In the EMDR approach to psychotherapy, psychological problems are viewed as being caused mainly by the cumulative effect of unresolved traumatic and adverse experiences (Shapiro, 2001). Self-harming behaviors are, in many cases, related to a lack of regulatory capacities and adverse experiences. Ross (2012) argues that traumatic memories and affect are frequently dissociated in individuals treated with EMDR, whether or not a diagnosable dissociative disorder is present. Self-harm behaviors usually serve the purpose of dissociating intolerable feelings and conflicts from executive awareness, so many of the behaviors can be understood as a dissociative coping strategy; EMDR therapy reverses the dissociation by reprocessing, desensitizing, and integrating the disavowed feelings and conflicts within the AIP model.

Additional issues that can be addressed in Phases 1 and 2 of EMDR therapy for people who self-harm are listed in Table 1.

TABLE 1. Therapeutic Recommendations for the Management of Self-Harming Behaviors (Mosquera, 2015)

1. Become familiar with the pattern of behavior associated with self-injury. It may be helpful to ask when it happens, how it happens, where it happens, and why it happens.
2. Figure out the pattern of self-harm (organized, disorganized, premeditated, impulsive).
3. If patients use objects to self-injure, find out what is being used, how these objects are obtained, if they are cleaned and/or disinfected, where they are usually being kept, if they have any meaning or not, and the reasons for choosing them initially and currently.
4. Explore the context in depth (private, public . . .).
5. Find out if patients usually self-harm alone or if they have ever done it in the presence and/or company of other people.
6. Explore the extent of the injury and the places on the body that patients tend to injure to seek medical help when the situation warrants it. Some cuts need stitches and will not heal easily without an intervention. If patients do not go to the doctor, other problems may arise, as for example, infections, which in extreme cases can have a very negative outcome, such as amputation of a foot or hand.
7. Help patients identify the different emotional states that precede and follow each episode. Explore how they feel before, during, and after self-injury.
8. Differentiate between self-harm and suicide attempts. They are very different issues, with different motivations, and each one has to be specifically addressed.
9. Find out possible triggers for self-harm with the intention of facilitating and proposing better short- and long-term adaptive alternatives.
10. Find out how patients live with their injuries: Do they hide them? Are they ashamed? Do they show them? Do they brag about them? This will provide significant information about the motivation and the reason for the behavior.
11. Confront dichotomous thinking, help patients take intermediate positions, and expand the global view of different situations.
12. Help patients identify their emotional responses and how their way of perceiving and interpreting different situations may influence these responses.
13. Help patients verbalize different emotional states so they can express their feelings with words and, above all, so they can identify the feelings that usually lead to self-harm.
14. Make suggestions that patients can implement to manage emotional distress.
15. Develop contingency action plans for critical situations that tend to "activate" patients and make them think about self-injury. This should be done regardless of their reasons for considering self-harm because we should remember that some do it for relief, others to "come back to reality," others to feel alive, and others to "get what they deserve."
16. Avoid excessive alarmed reactions, remaining calm, and focusing on solutions regardless of the severity of the behavior and/or injury.
17. Delve into the reasons that precede each self-harm episode, without getting into questions that may seem morbid for patients. It is important to explore the self-harm in depth and show interest without being intrusive or tactless.

Understanding Self-Harming Behavior as a Resource and Self-Regulating Strategy

Self-harm, in our clinical experience, most often occurs without the intent to die. In fact, often, self-harm is a suicide prevention strategy; it is not necessary to commit suicide to escape intolerable pain because an effective, temporary solution is available. Different people resort to self-injury for very different reasons. It is important to keep in mind that self-injury is often a self-regulation resource. A *security paradox* takes place in many cases, as one client explained:

> I always slept with a package of razor blades under my pillow. This gave me safety, thinking that if things got really bad, I could use them.

Self-injuries can be a substitute, short-term mechanism for healthy self-soothing and grounding and can be pathological but effective. In fact, the effect of self-harm can be so immediate that it may be difficult for the person to use other strategies that are effective but require a little more time and effort. When a client is overwhelmed by emotional pain, self-harm can provide a distraction; clients often feel that the physical pain is much more tolerable than the psychological pain. Self-harm can also be a way to dissociate a disturbing feeling or memory or to stop a depersonalization episode. When people feel empty, flat, and numb, they can use self-injury to "feel alive" or "feel real," as described by one client:

> In my case, self-injury has a specific goal: to feel better. Whenever I cut myself, I think that I won't do it again . . . I know it's not normal but it's like I can't help it. I don't always cut myself, but I think about it almost every day. Sometimes I don't do it, and I just do other things, but there are times when the pain is so strong, so intense, and so brutal that I can't take it any longer. It is just at those moments when I injure myself. Just after I cut myself, I feel good, relieved.
>
> Sometimes I go into a trance . . . I feel like I'm going crazy, that I don't exist, that I'm not real, it's like I was dead . . . Sometimes I burn myself just to check if I'm still alive and I still feel something.

If clients have been punished for feeling or expressing a certain emotion, they will tend to do the same to themselves when they are adults: "You punish yourself on the outside, trying to kill the monster inside." The self-harm has become a complex resource that now, in adulthood, appears to have more cost than benefit. Clients who self-harm tend to see the benefit but not the cost.

Clients often seek admission to a hospital when they realize that their cutting is escalating toward the point that it becomes life-threatening, which is consistent with their not wanting to die and with their using self-harm as a suicide prevention strategy.

Phase 2: Stabilization

When self-harm is based on a lack of self-regulation skills, as is often the case, it is necessary to offer clients healthier coping tools, in addition to working on the memories that are the basis of such dysregulation. To organize an adequate Phase 2, clinicians need to understand the underlying issues. In most cases, resource installation and reprocessing of the adverse life experiences related to the self-harm will be enough to stabilize the client. But this will only be successful when we do a history taking that allows us to get a deep knowledge of each case.

Resource development and installation (RDI) is recommended to expand coping responses in Phase 2 (Korn & Leeds, 2002; Leeds, 2009a, 2009b). Linehan (1993) has provided numerous treatment strategies for self-harm within her dialectical behavior therapy. These can be incorporated into the first two phases of EMDR whether or not the client meets full criteria for BPD. Clinicians should also keep in mind that prolonged stabilization procedures are not always needed or recommended. It is important to adapt to each client's needs and not be alarmed by the severity of the symptoms.

The following case illustrates how, in a high-functioning individual without severe, extensive comorbidity, stabilization can be achieved without a great deal of preparation and treatment can move quite quickly into the desensitization phases of EMDR.

Case Example 1: I See No Way Out

Martha, a 60-year-old woman, comes to therapy after many years of treatment. The treatment was focused mainly on symptom reduction through medication and frequent hospital admissions (many of them lasting over 3 months).

In the first session, the client says, "My problem is that my father raped me when I was 7."

She discloses numerous traumatic events involving her directly and many others where she witnessed how her siblings were abused and maltreated. She constantly gets flashbacks of traumatic episodes and tries to make them go away by self-harming. She states that self-harm is usually effective but that there are moments "when it was not enough" and that is when she becomes suicidal. By targeting her traumatic memories, beginning with the most intrusive images, she was stabilized. Her case illustrates how

suppression of affect and symptom reduction alone, without desensitization of the underlying traumatic memories and feelings, does not lead to stabilization yet alone resolution. The ineffectiveness of the previous approaches was identified in the first two phases of the EMDR therapy, and she was able to proceed to active reprocessing and desensitization without extensive stabilization being required.

Phases 3–7

One of the difficulties clinicians might encounter with clients who self-harm or who are suicidal is tolerating the emotional intensity of the pain. Clients lacking self-regulating capacities are often afraid of their own reactions and need to get a sense of safety and containment from the clinician. Many clients did not learn to self-regulate because their caregivers were overwhelmed with their own emotions. The therapeutic context can become a new learning experience for such clients.

A standard EMDR protocol can be used in most cases, complex dissociative cases being a possible exception. In complex dissociative cases, internal system work and other dissociative identity disorder (DID) techniques may be required in the stabilization phases of EMDR (Forgash & Copeley, 2008; Gonzalez & Mosquera, 2012; Ross, 1997, 2015; Ross & Halpern, 2009). However, once this work is completed, in our clinical experience, the standard protocol for Phases 3–7 can be employed.

One of the aspects of Phases 3–7 that might lead to confusion regarding the use of standard EMDR therapy procedures is the type of associations that can occur. For example, suicidal ideation can get triggered during reprocessing, but this is not necessarily an adverse effect and can be managed. When people are used to thinking about self-harm as a solution, as soon as they feel emotions that are upsetting, they will think about "hurting themselves." This does not imply that they have a plan or a wish to die, it is just how they usually think. From their perspective, it makes sense for them to consider self-harm because it has become a habitual coping strategy, and during reprocessing, this link between emotions and self-harm will be activated. If we keep going, employing an interweave, and remaining calm and secure, this will be processed and they will finally get to the adaptive link. Standard interweaves such as "this is a thought that often comes to your mind, it's ok, go with that" can be helpful to keep the processing contained and for allowing AIP to occur.

Another potential complication that concerns clinicians is the possibility of a client getting triggered after doing trauma work and resorting to self-harm. Although this can happen, it is not likely if the clinician is familiar with complex traumatization. One of the main problems is related to a common dilemma that occurs in doing trauma work, which is ambivalence within the client. A part of the client might want to go there (to get rid of symptoms that are experienced as intrusive), whereas another part might not feel ready to do this work. An attuned therapist will be attentive to this conflict, helping clients to identify their limits and not do more work than they are ready for. Such a basic intervention will be crucial for further safe interventions.

In more severe and complex cases, work with an inner child may be required, as illustrated in Case Example 2. In this case, full DID was not present but there was a dissociated inner child and the adult self had been phobically avoiding the inner child's feelings. The therapist proceeds with a DID-like intervention to increase communication and cooperation between the client and her own unresolved trauma, which is contained within her inner child ego state. The client must begin nurturing, healing, and caring for herself through the internal imagery of caring for her inner child. This is done with the therapist knowing that the child state is not a fully formed alter personality.

Case Example 2: Self-Care Work

After almost 2 years of stabilization work based mainly on psychoeducation, the therapist is trying to process a traumatic memory. The process seems blocked, and the therapist thinks that this could be caused by negative beliefs directly related to the procedure, such as "I am incapable of explaining what I feel" and "I am doing it wrong." The client lacks emotional regulation abilities and she is easily overwhelmed by her emotions. Self-harm is not addressed directly in this vignette; instead, the core negative self-beliefs and lack of healthy self-soothing strategies that drive her self-harm are the main targets:

T: (after bilateral stimulation or BLS): Is something different coming up for you? For a moment you stopped moving your eyes.
C: I don't know.
T: What do you notice now?
C: The same: a lot of anguish . . . I don't know . . . a lot . . . I am taking so much medication that words don't come to me. I notice sensations, but I don't have the words to explain them.
T: You don't need to tell me everything that comes into your mind or to have the exact word for it, I just need an approximate description. We will do a longer set, ok?

C: Ok. [BLS]
T: What do you notice now?
C: I notice anguish. [BLS]
T: What do you get now?
C: I'm losing concentration. [BLS]

It seems that the client has difficulties following eye movements, so we change to tapping.

T: What do you get now?
C: I still notice a lot of anguish and . . . ugh!!! This is very difficult, I can't. [BLS]
T: What do you notice?
C: I am becoming even more anxious because I can't focus on anything. I am feeling useless, I can't even do this.
T: Look at me for a moment [*client looks*]. What do you think you should do now?
C: I don't know . . .
T: You don't have to do anything now, you are doing fine. We are focusing on a physical sensation that you notice on a regular basis, we just want to relieve it a bit. Your mind is allowed to go wherever it needs to go. There is not a wrong way of doing this. [BLS]
T: What do you get?
C: I think that if I died, many people would be relieved.

The process is not working well. Even the word "relief" that the therapist said triggers suicidal thoughts. Everything positive seems to turn into a negative. [BLS]

T: What do you get now?
C: That I just want to die.

Verbal and nonverbal information do not fit together. The therapist checks in with the client.

T: How is the pressure on your chest?
C: It's the same.
T: Open your eyes [*client opens her eyes*] . . . You say the pressure on your chest is the same, but your body has changed dramatically. Can you notice any sensation that may be different?
C: Yes.
T: What do you notice?
C: It is a little bit more . . . more . . . a little bit more . . . more . . . I don't know. . . more . . . relaxed.

Even when BLS is having a positive, relaxing effect, the client's self-defeating tendencies are very intense. The client has difficulties noticing improvement and she tends to focus on negative aspects.

T: You are making a big effort, and this helps you disconnect for moments at a time. Although you are feeling bad, you are still trying. You seem touched by what I am saying [*client has tears in her eyes*]. Why?
C: Because you get me. I feel that you value me. You are the only one who appreciates what I do.

The client is extremely dependent on external regulation and lacks self-regulatory capacities.

Next Session. After difficulties reprocessing a memory during the past session, the therapist tries to do RDI.

T: Think of a time when you felt really good.
C: When I felt really good . . . [*takes a long time to think, long silence*].
T: Or when you were satisfied about something you did well.
C: It is difficult for me to feel good and to think I do something well.
T. Do you remember any time when this happened? Try to think of a situation, it would be very useful.
C: I am blocked.

When the self-care pattern is inverted, things can evolve in a reverse way. Trying to find a resource makes her feel worse because it makes her realize how many things she is lacking. This becomes a new way of blaming herself.

T: Is it because of the question I asked?
C: Yes, because I don't remember any.
T: Ok, so you can't think of anything positive?
C: No.
T: What would be positive enough for you? Could you try thinking of something?
C: I don't know how.

The client has an extremely negative view of herself, and this interferes with any intervention attempted in therapy. Her self-care patterns are extremely dysfunctional. Even if she is aware of the early experiences that feed her lack of self-worth, their influence does not change, neither with psychoeducational interventions nor with EMDR processing. She has learned many emotion regulation skills and many new abilities but she cannot use them to improve, and suicidal thoughts and acts are very present and intense. The client is completely dependent on external reassurance (even though it does not work).

C: I don't know, I always depend on what others say in order to value myself. I can't do it on my own, I don't know why . . . I should learn to do that, to value myself.

T: And how could you learn that? [*Trying to get her to think*.]
C: I don't know, I have no idea. I've never done it.
T: Where did you learn not to value yourself? Could you think about that?
C: I don't know . . . I think I have never valued myself.
T: How about when you were little?
C: No.

The client does not realize the connection between rejection and hostility in her childhood family environment and her negative attitude toward herself. To focus on self-care patterns, the target will be the image of the child she was when the pattern was learned. Because she has no images, the target will be a picture.

T: When you look at pictures of you from when you were little, what do you feel?
C: Sadness . . . everyone says they would love to go back to childhood. I wouldn't, I feel it was sad . . . I don't like it at all.
T: Do you have pictures from when you were little?
C: Very few . . . I have one from when I was little. I took it from my mother.
T: Which picture did you take?
C: One from when I was about 1 year old. I am wearing a dress, a short one, like those where you can see the diapers.
T: Why did you choose that picture?
C: Because I had a very sweet gaze. I like her gaze.
T: When you look at this picture, what do you feel towards yourself?
C: I see a sweet child, a sad child, I don't know . . . she seems unprotected. I feel like holding her.

At this stage, the client does not present a dissociative phobia toward this emotional part. From her adult self, a tendency to take care of this little girl emerges spontaneously. This dissociative part does not seem to have a strong mental autonomy. There are no significant barriers between the adult state and the childhood state. When she looks at the child, she is not overwhelmed by emotions. There are no elements that need a specific intervention, so we can focus on reinforcing this positive tendency that appears.

T: It would be great if you could . . . I think that many of the things that you don't understand come from there, from this sensation you already had when you were very little. If you could hold that little girl now, what would you do?
C: Hug her and cuddle her.
T: What would you say to her? Try to imagine that little girl. Look at that little girl, look at her in the eye and tell me what you would say?
C: That I will take care of her, that nothing is going to happen to her.
T: Close your eyes and notice that, think about that, let this little girl . . . let this little girl know how you feel. [BLS]
T: What do you get?
C: It's like I want to cry.
T: Ok, go with that and cry if you want. [BLS]
T: What do you get now?
C: I feel like holding her and protecting her.
T: Ok, let her know. What she didn't know as a child and what you now know as an adult: that you can protect her. [BLS]
T: What do you get now?
C: I tell her that I will cuddle her and tell her stories.
T: Go with that. [BLS]
T: And now?
C: That I will protect her, that I won't leave her alone.
T: Ok, let her know that; it's important. What do you get?
C: That no matter what she does, I will always support her.
T: Go with that. [BLS]
T: And now?
C: That she can always count on me.
T: Notice that. [BLS]
T: And now?
C: That I won't bother her.
T: That's it, very important. [BLS]
C: I will allow her to be herself.
T: Just notice . . . these are such important things. [BLS]
T: What do you get now?
C: I tell her that she will be able to do whatever she wants. [BLS]
T: And now?
C: I will try to make her happy.
T: Very important, notice that. [BLS]
T: What do you get?
C: That she will be the most important thing in my life.

After all these positive elements, some disturbance appears. We need to explore whether it comes from the child ego state or the adult self.

T: What do you get now?
C: I am a little disturbed.
T: Is this disturbance yours or hers?
C: Mine.
T: Go with that. [BLS]
T: What do you get now?
C: This is very strong.

T: What is?
C: The throbbing.
T: Go with that sensation. [BLS]
T: What do you get now?
C: It still is very strong.
T: Ok, go with that. [BLS]
T: And now?
C: I am disturbed, it is as if I couldn't breathe well.
T: Can you keep going?

Client nods.

T: Take a deep breath, open your eyes. When you think about this little girl and all of the things you have told her, such important things, what are you thinking now? How did it feel to be able to say those things to this little girl?
C: It was good in a way, but I didn't have any of that.
T: Is this why you got upset?

Client nods.

T [modeling]: You can try saying to this little girl that although she was so deprived of affection, you are an adult now, and you can take care of her.
C: I don't know because I felt a lot of responsibility.
T: Responsibility?
C: Yes, I think so.
T: What does that mean?
C: I thought, "I am saying this, but will I really be able to do it?"
T: You are very responsible, what do you think?
C: I don't know, I don't have children because I wouldn't want any child to go through what I went through, to have such a sad childhood as mine, I don't know.

When the client has difficulties imagining herself performing an adequate caregiver role with the little girl, we help the client to connect with a caregiver role in other areas of her life and then "turn" this role toward herself. Many severely traumatized people adequately take care of other people, even when they do not take care of themselves at all.

C: I don't know if I would be able to have a child and make him happy.
T: How do you connect with your nephews? [*The therapist knows that they adore her.*]
C: Good, but they are my nephews, they are not with me all the time.
T: I am asking how you connect with them, how they feel when they are with you?
C: Good, yes, but they are my nephews . . . I don't have them the whole day.
T: But you have yourself the whole day.
C: Yes.
T: And it is important that you learn to care for yourself, to value yourself . . . to give yourself what you lacked as a child. Nevertheless, now you have yourself and you are doing many things to take care of yourself.
C: Yes, it's true, I now do many things to protect myself, I do notice that.
T: Yes, that's why I'm saying this because now you do things to care for yourself and protect yourself, so I do think you can communicate these things to the little girl. I think it is important to "heal" that sadness from other stages of your life that has accompanied you all your life.
T: You seem calmer now.
C: Yes.
T: Why is that?
C: I don't know because it calms me down to listen to what you are saying.
T: Does it make sense?

Client nods.

T: I think it's important to work with past issues, to see that you feel many sensations that you don't quite understand, to be able to heal and learn that you have yourself, to learn to value yourself. Is this ok with you?

Client nods.

T: Does it make sense?
C: Yes.
T: The next time we meet, you will hug this little girl.
C. Ok.
T: How are you feeling now?
C: Good.
T: Will you keep protecting yourself?
C: Yes.
T: You have realized that this is important, right?
C: Yes.
T: I am glad, really glad. I didn't expect you to say this for now.

Client nods.

T: I was waiting for you to realize this.
C: Yes [*smiles*] . . . We are making progress.
T: Yes, we are.

Next Session

In the next session, after years of pleasing others to be accepted, she begins to be able to set boundaries for

the first time, after the therapist had worked on this issue for years. She changed from a submissive attitude to a more secure one. This also becomes obvious in her body language; she has an upright body position.

C: [*Explaining what she said to a person who was dependent on her.*] So I told her, "We will talk about my illness today. I get very anxious and very sad when you tell me your problems all the time. This might be healthy for you, but it is unhealthy for me. So we must reach an intermediate point. This should be a healthy relationship for both."
T: Very good!!! Very good, Susan.
C: I will help you as much as I can, by maintaining these boundaries. She reacted well.
T: Being clear, explaining things . . .
C: Yes, I also told her: "If I keep tolerating this, I will be very ill and won't be able to help you anymore. Then I would have to get away from you, and the relationship would be over, I won't be able to help you or anybody else, and I will be ill." And she said, "No, no, I don't want that!" And that was all.
T: You have managed this very well and you see she reacted well. The other way would be worse for both. You are setting a good example for her.

The client can now focus on well-being and positive aspects of herself. She seems not to need as much reinforcement from the therapist as before, spontaneously explaining her achievements. She is more active and her mood is fine. The previous intervention with the self-care procedure has changed how she feels and acts. It is as if this intervention had been a turning point, which allowed the client to use all the skills she had learned in 2 years of therapy. From this moment on, it was possible to work with the standard protocol on traumatic issues. She could even describe the "top 10" list of traumatic events without becoming overwhelmed like she did before.

Her previous unhealthy self-care pattern was blocking improvement and, in this case, turning self-care into a positive and healthy pattern was not complicated. In other cases, specific interventions to overcome dissociative phobias, integrate healthy information about attachment, develop differentiation, or regulate emotions will be needed. Sometimes, several sessions are needed to achieve changes, and healthy self-care has to be constantly interwoven into many other interventions.

Identifying Possible Targets for Desensitization

Proper identification and reprocessing of traumatic memories and unresolved internal dilemmas can put an end to self-injurious behavior. The target typically will not be the self-harming behavior itself but the circumstances surrounding the first time at which it occurred, the negative beliefs associated with the behavior, and memories that can be identified through an affective bridge. Examples of possible targets (Mosquera, 2014) include the following:

- Emotions, feelings, beliefs, and experiences of intrusive memories prior to self-harm are often connected with specific biographical events.
- The target would not be the self-harming behavior in itself unless the behavior led to terrible consequences (for instance, the client ending up in a wheelchair and having repetitive thoughts about what she did).
- The circumstances surrounding the first time the client self-harmed
- The origin of the negative beliefs associated with self-harm
- Specific memories related to current triggers; these memories can be identified through the affect bridge.
- Somatic sensations that trigger self-harm (sometimes, there are no cognitive or visual memories but only unbearable sensations)
- Emotional states associated with self-harm (feeling empty, worthless, or guilty)
- Idealized reactions from family members (the first time the client went to the hospital after self-harm and then saw concern in the faces of loved ones or heard them express love)

Conclusion

In working with self-harming behaviors, it is crucial to explore and intervene beyond the symptom itself. Emotions, feelings, beliefs, and intrusive memories occurring prior to self-harm are often connected with specific biographical events that need to be explored and addressed. When self-harm is based on a lack of self-regulation skills, it is necessary to offer clients self-regulatory tools, in addition to working on the memories that are at the basis of such unhealthy self-regulation.

A dysfunctional pattern of self-care learned in childhood often continues into adulthood. Changing patterns with EMDR therapy requires a directed intervention and is not achieved solely by processing specific memories or traumatic events. Clients must learn to look at themselves through different eyes than those of their abusive primary caregivers, with whom they have identified. They must pay attention to their needs and learn to care for themselves and be cared for by others in a balanced, healthy way.

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