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# TREATING PERSONALITY DISORDERS WITH EMDR THERAPY

Dolores Mosquera

## Abstract

Eye Movement Desensitization and Reprocessing (EMDR) Therapy has been shown to be an effective, efficient, and well-tolerated treatment for posttraumatic stress disorder (PTSD) and useful for both adult and childhood onset PTSD. Since there is ample evidence of the contributions of early, chronic, severe interpersonal trauma, early attachment disturbances and negative life experiences in the development of Personality Disorders (PD), the indications for EMDR treatment of individuals with personality disorders seem clear. This article focuses on understanding the relevance of adaptive information in individuals with personality disorders. Specific adaptations for borderline, narcissistic and antisocial presentations during the different phases of EMDR will also be addressed.

**Key words**: EMDR, trauma, Personality Disorders, AIP Model

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Dolores Mosquera
Institute for the Study of Trauma and Personality Disorders (INTRA-TP), A Coruña (Spain)

**Corresponding author**
E-mail: doloresmosquera@gmail.com

## The AIP model and personality disorders: the relevance of understanding adaptive information

Working with EMDR therapy implies a shift in paradigm: going from a symptom-based classification used by the DSM or the ICD to the EMDR perspective, based on the Adaptive Information Processing (AIP) model. When working from other approaches, using a symptom-based perspective may make sense: similar symptoms, similar interventions. In the EMDR approach to psychotherapy, psychological problems are viewed as caused mainly by the cumulative effect of unresolved traumatic and adverse experiences (Shapiro 2007). These are the experiences that influenced how the person learned the behavior or symptom. Thus, the similar symptoms can be related to completely different events. Although we approach cases from the AIP perspective of the experiences that generate present problems, we need to use a general classification that provides us with a common language to translate our findings to professionals that do not work with EMDR.

In simple PTSD, the focus of our work is three-fold: memories of past events, present triggers, and projections for the future. We start by identifying both the presenting problems/symptoms and the current triggers, and then we move on to determining which memories are connected to the current problems/symptoms. These memories are considered dysfunctionally stored information that are maintaining and feeding the current problems. Once the dysfunctional memories are reprocessed, it becomes possible to work on the present situation as well as on a projection for the future.

In Personality Disorders, things become more complicated and we cannot always begin working with past traumatic situations. As with all cases, we must identify the current problems/symptoms, as well as the triggers. However, identifying the memories connected to the current problems/symptoms is not always easy. We can get a "cascade of memories" blocking the system or defensive responses that do not resolve easily. Sometimes, depending on the severity of the case, it is even complicated to complete any trauma work in the earlier phases.

The memories of these experiences, which are dysfunctionally stored, are included in the more general term known as Dysfunctionally Stored Information (DSI; Gonzalez et al. 2012). It is critical to keep in mind that DSI goes beyond memories and includes personality structure, dysfunctional positive affect, as well as the multiple layers of defenses we find in personality disorders cases.

### *Understanding Adaptive Information in Personality Disorders*

Adaptive information is not always available in patients with Personality Disorders. This lack of availability is not necessarily related to information that has been dissociated; sometimes it simply has not been learned. Patients with PD have often experienced many adverse experiences and have difficulties when it comes to emotional regulation; they tend to self-regulate in ways that were helpful in their environment (ignoring their needs, blaming themselves for everything, self-harming and being very critical). Due to their defensive structure, when using EMDR with Personality Disorders, can seem very confusing. What seems to be adaptive is not always adaptive and EMDR reprocessing

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sessions could seem to be working in a way that could be confusing for the novice EMDR clinician, since they may not end with the patient feeling the initial relief that could be expected. In the next example, we can see how the reprocessing of a maladaptive defensive attitude leads to reprocessing the adaptive realization of a painful reality.

Case example:

A 40-year-old woman is having difficulty functioning in daily life. She goes out frequently, drinks, gets into fights, and spends most of the time in bed. The therapist is trying to work with a more recent target, so that the patient can have a positive first experience with EMDR processing. When asked about a more recent situation that has been bothering her, the patient says “My parents are living my life. I should be the one taking care of my son, not them”. The woman is angry at her parents, especially her mother, for what she is experiencing as taking her child. Although this did not seem to be a traumatic memory, the therapist identified it as dysfunctionally stored information and decided to go on with this target. The therapist gathered all EMDR Phase 3 elements. The image representing the worst part of the memory was “When I see my son sitting on my mother´s lap telling her that he loves her”.

By the end of the processing, the patient said, “I get that it´s my fault. I am very unfair. I don´t take care of myself, and I neglect my son. My mother takes care of him and then I blame her for it. How could he not love her if she is the one that looks after him?” This led to an important insight and realization, which helped change the patient´s attitude regarding her mother and her responsibility with her son.

If this patient´s mother would have been cold and unloving when the patient was very young, we could understand the image of her son in her mother´s lap as a trigger of what she did not have. But this was not the case. The patient´s experience was a defense that protected her against the painful reality: “I am not doing enough, I am not a good mother”.

This is just an example to remind us to broaden the scope of targets and the way we conceptualize defensive personality structures like those seen in Personality Disorders. As we know now, the DSI that will be important to process EMDR treatment may include much more than just the memories of negative experiences. In this case, the adaptive information the patient needed to realize came up after processing the defense.

### *Dysfunctional Positive Affect (DPA)*

The power of positive memories, experiences, and affect – including feelings of attraction, appreciation, feeling ‘special’ and receiving reassurances, etc.– has been broadly recognized by trauma therapists and in the literature. Nevertheless, there are times when positive affect is more dysfunctional than adaptive. As was mentioned previously, DSI goes beyond memories of adverse experiences, and this includes dysfunctional positive affect (DPA).

Dysfunctional positive affect can often block full therapeutic access to traumatic incidents that have occurred and interfere with realization. The strong, positive memory image functions within the person’s personality to protect the individual from **being overwhelmed by the impact of unprocessed, disturbing memories.** In these instances, the effectiveness of Standard EMDR is likely to be compromised because full conscious access to the disturbing memories is blocked. Clients can significantly benefit from reprocessing these seemingly “positive experiences” (Knipe 1998, 2005, 2009, 2014; Mosquera 2010, 2016; Mosquera and Knipe 2014, 2017; Stowasser 2007, Steele and Mosquera 2016).

Idealization – an inaccurate and distorted positive image of self or the other (Knipe 1999, 2005, 2009; Mosquera and Knipe 2015) – is a typical example of DPA. In some case with pathological idealization defenses, this might be the only available point of entry into the dysfunctional trauma memory network that is the source of the client’s negative feelings. By targeting and reprocessing memory images representative of the positive idealization, these can be weakened in the same manner as dysfunctionally stored “negative affects”, such as shame or fear. Once the DPA is resolved, we can access the underlying, unfinished traumatic issues and process them.

### *Are Adaptations Always Needed in Personality Disorders?*

Personality Disorders pose many challenges in different areas. One of the main difficulties for clinicians is to manage countertransference issues and affect tolerance while preventing becoming confused by the chaotic presentation. Sessions can get intense, and we need to be ready to navigate the emotional storms that may arise during the different treatment phases. Case conceptualization is crucial to differentiate whether we can proceed in a standard way or need adaptations.

Although it is essential to be cautious in the more complex cases, proceeding in the standard way – gathering a complete history and not needing a long stabilization phase– is possible in many PD cases. In fact, often the best stabilization procedure is to apply the EMDR Standard Protocol (Mosquera et al. 2014) and reprocess the earliest memories in an orderly way.

## Treatment planning and target identification

In Personality Disorders, selecting targets may be challenging for a variety of reasons.

There may be too many relevant targets when clients have a history of many adverse life experiences and many unique or recurring traumatic experiences. Also, in complex trauma cases, amnesia or fragmented memories may interfere with finding targets from the past. In addition, defense mechanisms may not allow the identified memories to be addressed directly. Sometimes, defenses themselves need to be targeted and reprocessed until sufficient affect tolerance is developed. Generally, as the patient achieves mastery in working with stressful situations, s/he will progressively feel prepared to proceed with the most challenging material.

Although we must take into account each client’s characteristics, the following are some criteria for target selection (Mosquera et al. 2014) that can offer some interesting starting points:

1. **Intrusive memories and recurring thoughts and sensations**, which can lead to the associated episodic memories, either directly or via affect bridge.
2. **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 connected to current problematic behavior, the potential effect on

client improvement is very high.

3. **Current triggers** related to the worsening of symptoms. If there is any change, clients will see the benefit directly and immediately.
4. **Past event** that is not associated with a long string of painful experiences. For example, working on the memory of a car accident may be easier than working with attachment-related events, and the effect of processing such memories is more "visible".

In working with memories that are part of a cluster, it is crucial to work with *limited reprocessing* in the first few sessions. Going back to target more frequently can be a good way to keep the reprocessing contained. By doing so, we prevent becoming overwhelmed and opening multiple targets, which may lead to re-traumatization and later wanting to avoid EMDR work altogether or even dropping out of therapy.

As a general guide, it is important that we facilitate, as much as possible, a positive first experience with EMDR for the clients. The central idea of all initial experiments is to introduce the reprocessing of memories with EMDR as an experiment with no possibility of error. If the memory is reprocessed, we can improve things that are now most troublesome for the client. If the memory cannot be reprocessed, this gives us essential information on how to structure the therapeutic work. It is not good for clients with familiar feelings of "I do everything wrong" to leave their first experience of EMDR with a confirmation of their core negative belief.

Another aspect to keep in mind is that some relevant targets might not come up during the history taking. Current symptoms might be rooted in early everyday experiences, but clients with attachment disturbances may not consider these experiences to be relevant. They may regard them as normal when compared to their more traumatic experiences.

## *Examples of Target Selection for Different PDs*

**Narcissistic Personalities**

First crash with reality: Exploring narcissistic injuries can be useful to understand the origins of the narcissistic false positive self. We may begin with the first "crash with reality" (See Mosquera & Knipe 2015 for more information).

as a target, continue with the worst and the most recent one (similar to what is done in interventions for panic attacks). Only after we have worked through the primary defenses, when there is a strong alliance and the patient has gained a sense of mastery, can we proceed with trauma work.

**Antisocial Personalities**

Fractioning: "Baby steps" are recommended using the "tip of the finger" strategy (González and Mosquera 2012) rather than reprocessing early traumatic events and selecting the worst part of the memory. We can reprocess part of the emotion or a fragment of a memory to deal with the intense emotions gradually. It is recommended to go back to target frequently to keep clients inside the "window of tolerance" and give them a sense of control during the process that can allow them to delve deeper as therapy evolves.

Targeting defenses: Sometimes, defenses themselves need to be targeted and reprocessed until sufficient affect tolerance is developed. By targeting the defense, the client may be able to connect with the vulnerable aspect of his personality and gain understanding of how he learned to respond in such a way.

**Possible targets related to self-harm and suicidal ideation**

Emotions, feelings, beliefs, and experiences of intrusive memories prior to self-harm are often connected with specific biographical events. These biographical events might not come up during the history taking, but it will be obvious when we explored what triggered the crisis. Identifying and reprocessing these memories can bring an end to the self-harming behavior. The target would not be the self-harming behavior in itself unless the behavior led to terrible consequences.

Other possible targets are:

- Memories of the circumstances surrounding the first self-harm incident
- Memories that are at the origin of the negative beliefs associated with self-harm
- Specific memories related to the actual triggers
- Memories related to hopelessness and despair
- Memories of idealized reactions from family members (the first time they went to the hospital and looked concerned or expressed love)

There are many possible options from which to start when working with self-harm and suicidal behaviors. Many of the memories to be reprocessed can be identified through the affect bridge (Watkins 1971). In some cases, we can also go from somatic sensations that trigger self-harm (sometimes there are no memories but unbearable sensations) or emotional states associated with self-harm (feeling empty, worthless, guilty).

## Important issues along the different EMDR phases

In the EMDR approach to psychotherapy, psychological problems are viewed as being mainly caused by the cumulative effect of unresolved traumatic and adverse experiences (Shapiro 2001, 2007). EMDR therapy has been shown to be an effective, efficient, and well-tolerated treatment for posttraumatic stress disorder (PTSD; Bisson & Andrew 2007, Foa et al. 2009, Ursano et al. 2004) and is effective for both adult and childhood onset PTSD 54 (Adler-Tapia & Settle 2009, Field & Cottrell 2011, Korn 2009, van der Kolk et al. 2007).

In EMDR therapy, the client is directed to mindfully notice what happens to representations of disturbing or dysfunctional visual images, self-referencing negative thoughts, emotions, sensations, action urges, and self-statements while attending to a series of sets of bilateral stimulation (BLS) involving alternating eye movements, taps, or auditory tones (Leeds, 2009; Shapiro, 2001). EMDR uses an eight- phase approach and addresses past memories, current triggers, and future situations. To assess changes during reprocessing, two scales are used: Subjective Units of Disturbance (SUD) scale and Validity of Cognition (VOC) scale.

In the first two phases, the therapist collects client history, builds therapeutic alliance, and prepares the client for the reprocessing phase. Phases 3 through 7 focus on reprocessing a targeted experience. In Phase 3, the client identifies a representative image for the target, related negative and positive self- statements,

emotions, and physical sensations. The client rates the validity of the positive cognition (VOC: 1 not true, 7 totally true) and the subjective disturbance of the emotion (SUD: 0 no disturbance, 10 worst possible disturbance). During Phase 4, client notices how elements change while attending to alternating BLS (generally eye movement). Phase 4 ends when the level of disturbance (SUD) reaches 0. In Phase 5, BLS is applied to reinforce the linkage between the experience and the positive statement until the VOC reaches 7. In Phase 6, clients report any residual sensations that need to be reprocessed. In Phase 7, the clinician makes sure the client reaches closure. Clients are asked to take internal notes, understanding these events experiences as a part of the process. In Phase 8, the clinician reevaluates the effects of the reprocessing and monitors the client's progress.

## *Phase 1. History Taking*

How can we get realistic information from a client who sees him or herself through the eyes of the abuser? How can we expect clients to be able to care for themselves when nobody taught them how to do it? How can we expect positive connections in cases where clients were treated like objects and not human beings? How can we expect a person who is blocked in defensive attitudes to allow themselves to be vulnerable with us?

The foundation for stabilization and an adequate treatment plan is built upon:

- establishing rapport,
- developing a clinical assessment and case formulation based on the AIP model,
- identifying relevant dissociation and attachment classification(s), and
- understanding the client's current strengths and difficulties.

Therefore, one of the main things to keep in mind is not to focus exclusively on traumatic events. Patients need to be able to identify skills, resources, and strong points. Sometimes this information is simply hidden, since patients keep seeing themselves through the eyes of the abusive figures. With the help of the therapist, they can start identifying positive aspects.

Both clinician and patient may tend to move too rapidly toward identifying and/or uncovering traumatic material. In most cases, we should first understand the patient's capacity to cope with day to day challenges; the degree of dissociative symptoms, dissociative parts and trauma related phobias; the challenges of confronting traumatic material, and the defenses related to the different personality disorders. It is important to 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).

**Common difficulties in Phase 1**

- ✓ In complex trauma, taking a complete history is not always possible and can be destabilizing. Amnesia, for example, is common in severely traumatized people and complicates obtaining intake information.
- ✓ We should be careful not to "open too many doors", since asking about trauma too soon can be overwhelming.
- ✓ For severely traumatized people, trusting the therapist is complicated.
- ✓ Lack of differentiation and enmeshment are also common in identity confusion cases. In such cases, we need to start teaching basic skills and introducing very fundamental adaptive information.
- ✓ Lack of realization can also interfere with history taking. When faced with structural dissociation, we need to keep in mind that this lack of realization is helping avoid being in contact with the most complicated aspects of their traumatic experiences.
- ✓ Some patients can also have difficulty identifying or accepting certain "targets". They do not recognize those experiences as disturbing or problematic. The relationship between past experiences and present symptoms is not always evident to them.

## *Phase 2. Preparation and Stabilization*

One of the more significant challenges for EMDR therapists is to avoid extending the stabilization work when not needed. Some clinicians believe that we must work on psychoeducation and emotional regulation for years until patients end up in similar conditions as individuals with simple trauma, and then start with the trauma work phase. However, some PD clients who are severely deregulated and show dangerous risk behaviors

| Personality Disorders without relevant dissociative symptoms | Personality Disorders with relevant dissociative symptoms |
| --- | --- |
| •Develop reflective thinking / functioning<br>•Introducing adaptive information about emotions, self-harming behavioirs, boundaries and defenses<br>•Resource development / skills building<br>•Self-care work: developing a positive stance towards the self.<br>•Working with differentiation | •Exploring the internal system<br>•Grounding<br>•Maintaining dual attention<br>•Specific psychoeducation about trauma responses<br>•Differentiation: The danger is over<br>•Working with parts / aspects (drawing, action figures, etc.) |

can easily tolerate working on traumatic memories with EMDR.

As mentioned previously, this may at times be the most powerful stabilization maneuver we can perform (Mosquera et al. 2014). Nevertheless, we can also encounter the reverse situation. Some clients become destabilized just by touching on early memories that are too painful. This is not necessarily predictable based on the functional level of the individual, the presence of risk behaviors, or the degree of emotional regulation.

The capacity to stay present is crucial in these cases, as well as identifying the resources that are missing or those which could be reinforced to prepare patients for processing.

**Common difficulties in Phase 2**

- Resources for strength, courage or discernment may be initially more helpful and better tolerated than "calm" or "safety" in many cases, regardless of the type of Personality Disorder.
- Borderline clients will not be picky about words. For instance, they are OK with feeling vulnerable and will want to work on feeling safe. They know they are highly sensitive and appreciate others realizing this. But narcissistic and antisocial patients will be pickier about words. They will not want others to think of them a "weak", "inferior" and "needy". This would activate defensive attitudes. Patients with antisocial traits for instance, will not recognize the need to feel safe, since this would imply that they cannot protect themselves.

**Useful interventions**

The following are some useful interventions for Personality Disorders in Phase 2 (Mosquera 2015)

The primary goals of both groups are to reduce internal conflict and promote empathy, collaboration, and compassion. This will lead to a better functioning individual and increased integration.

**Indicators that 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. Knowledge of clients, their history, their defenses, and their peculiarities, are the fundamental criteria that guides decision-making processes.

It is not only working with trauma what 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 vulnerability in working with self-care, because their core defensive identity is "I am strong" and looking into the eyes of the helpless inner child implies an intolerable emotional intensity. Other people may reprocess a part of the memory associated with various emotions and feelings. However, the idealization of early dysfunctional attachment figures may come up amidst the reprocessing and block it: it could be too soon to leave that defense, which would expose individuals to assume "they had no parents" and "nobody loved them".

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 PD, given the high prevalence of these symptoms among some borderline and antisocial 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 red flags.

## *Phase 3*

People who grew up in abusive, neglectful or less than good-enough environments have internalized many of the messages they received (overtly or covertly through the caregiver´s behaviors). Traumatized clients often continue to see themselves through the eyes of the abuser and give us many negative "learned cognitions".

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

**Common difficulties in the different PDs during Phase 3**

Borderline Personality: Patients with BPD can easily give us twenty negative cognitions (NC). It is important that the NC is related to the target and not to how they usually see themselves. 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".

Narcissistic Personality: The therapist should not push too hard to get a self-referencing negative cognition. Jim Knipe (1998) says that an all-purpose NC for targeting moments of narcissistic injury would be: "It still bothers me" (very mild compared to other NCs, yet one that most narcissists are likely to accept). We should be careful not to accept positive cognitions such as "I'm the best" or "I'm superior", even though it is something they will frequently mention when asked about the PC they would like to have.

Antisocial Personality: Just like in Narcissism, therapists should not push too hard to get a self-referencing negative cognition. To identify the dimension can be enough in these cases. It can also be helpful to allow the patient to express negative cognitions about others to understand what that says about them. Anger at others can be the result of feeling vulnerable, for example.

The positive cognition must not be defensive and should be realistic:

Defensive PC: I am untouchable / unbreakable

Realistic PC: I can protect myself

Defensive: I don't have any feelings - I am tough

Realistic: I can learn to understand and accept my feelings.

With Antisocial and Narcissistic presentations, it may be useful to change the word *disturbance* for the word *bothersome* and begin with targets that "bother them a little".

## Phases 4 to 7

### Examples of common difficulties in the different PDs

Sometimes the therapist may need to take an active stance to guarantee that some emotions or aspects are included in the desensitization phase. Interweaves such as "Allow yourself to feel ALL your feelings" or "Let it out. It's ok". might be needed. General examples of situations we might encounter during Phases 4-7 with PD are the following:

*Antisocial*: They will need help to connect or stay with vulnerable emotions, especially in cases where to feel fear or sadness was not permitted and the person was only allowed to be "tough".

*Narcissism*: Feelings related to being like others or feeling inferior will be complicated when the client was only allowed to be a perfect-idealized child.

*Borderline*: They will need help with their intensity, given that at times they have learned that their emotions "frighten others".

Another possible difficulty with some personality disorders is to notice and stay with anger, which may be complicated for some patients. Some might feel they could explode uncontrollably, and may even be afraid to hurt the therapist. It is important for the patient to sense that we can take whatever comes up for them. Some examples are: intense abreactions in BP; suicidal ideation, urge to hurt themselves; anger in Antisocial and BPD, and despise or verbal attacks in Narcissists.

There are some specific difficulties in **Phase 5** that are worth mentioning. We should not always expect "good cognitions". In some cases, apparently negative cognitions are actually positive. "I am guilty" is more adaptive than "Others are responsible for my problems" in situations where the patient has to assume responsibility for their behavior. "I am weak" is true adaptive information for those who have never before acknowledged their vulnerability.

Such examples of reprocessing may seem like "a reversal reprocessing" and it is important to understand that what is coming up is adaptive, like in the example of the woman who was blaming her parents for her situation and realized that she was responsible for it. Clients might also try to "avoid crying" because the family system covertly disparaged it or because clients were punished or insulted if they cried. Some patients may also 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, or remain at a cognitive level to avoid connecting to pain or sadness.

## Phase 8

The revaluation phase is crucial for an adequate reprocessing of targets. There are some particularities to this phase too.

### Examples of common difficulties in the different PDs

BPD: It is important not lose focus and to avoid "target hopping". The patient 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.

Antisocial: It is important not to lose hope when the client does not report positive outcomes, since sometimes they need to "confirm" the change is real before they let us know they are noticing it. It can be helpful to explore the problematic behaviors to have an idea of the outcome (for example a patient who is no longer engaging in fights, drugs or robbery might not tell us "he is doing better", but his behavior will let us know something is shifting).

Narcissism: Just like in antisocial, it is important not to lose hope when the client does not report positive outcomes. Sometimes they do notice changes but they are experienced as "not being enough", belief which is often part of the problem. It can be helpful to explore any changes in relationships (sometimes others notice the changes before they do and we can observe changes by how they relate to others).

## Conclusions

EMDR is an efficient approach for the treatment of personality disorders, especially those most related to early adverse experiences, trauma and dissociation. These difficult situations generate dysfunctionally stored information that is presented as memories of adverse or traumatic events, dysfunctional positive affect, or other types of defenses, which may be necessary to reprocess before we can work directly with trauma.

The EMDR Standard Protocol can be used in many cases, improving the client's condition quite rapidly. However, it is important to be aware of certain difficulties that are specific to those personality disorders most associated with traumatic events, such as borderline, antisocial and narcissistic personality disorders. By doing so, we will improve the chances of treatment being fully effective.

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