Chapter 1
The Challenge of EMDR Trauma Treatment

Eye Movement Desensitization and Reprocessing (EMDR) has been an amazing game changer for therapists. We've been able to get exceptional treatment results we never thought possible. But sometimes the treatment goes sideways. Traumas we expect to process through easily do not process at all, or the symptom reduction we expect to see never happens. In some cases, clients take a turn for the worse. Whenever EMDR disappoints, there’s a reason. I’ve written this book to share my ideas about why this happens and to offer a set of tools to help EMDR therapists deliver the best possible healing experience. Let's start with a review of some basics.

Adaptive Information Processing

EMDR is based on the tenets of Francine Shapiro’s Adaptive Information Processing (AIP) model, which posits that our brains are hardwired for healing, designed to naturally take emotional turmoil to a place of adaptive resolution. Our brains help us process the painful emotions of ordinary disturbing events at night during Rapid Eye Movement (REM) sleep. When we experience extraordinary traumatic events that overwhelm the nervous system (like surviving a house fire), REM sleep may fail to process it. As long as it’s unprocessed, a later event (like seeing a bonfire) can awaken the old trauma, often unconsciously, and trigger old painful emotions, sensations, and beliefs. Thankfully, with EMDR we can rapidly process overwhelming traumatic events to adaptive resolution so they will not get triggered again. Some believe that the Alternating Bilateral Stimulation (ABS) we use during EMDR taps into the brain’s mechanism for healing trauma during REM sleep.

Definition of Trauma

Trauma is often defined broadly as any kind of deeply distressing or disturbing experience that overwhelms one's ability to cope. Shapiro went a step further to differentiate big T from small t traumas. Big T traumas have a life-threatening component—like surviving a deadly tornado, witnessing a murder, or enduring a life-threatening assault—the kind that leads to post-traumatic stress disorder (PTSD). Small t traumas, she said, are "rampant throughout childhood”—like being bullied in grade school or disparaged by parents—experiences that are not life threatening but painful enough to leave a long-lasting emotional wound. Shapiro’s early clinical research led her to conclude that EMDR can successfully treat both categories of trauma.

My Early Experience with EMDR

I took my level one EMDR training in 1995 as soon as I started my LPC internship. I began using it right away. I followed Shapiro’s lead, applying EMDR to both big T and small t traumas. One of my very first
EMDR clients was Lester, a shy, soft-spoken, middle-aged man with chronic insecurity and anxiety. He was in his early forties, married, with twin girls. He’d always been anxious and insecure, but when he came to me, it was a big problem. He’d found flirty emails between his wife and a man he didn’t know. This discovery heightened his feelings of insecurity and anxiety, leading him to behave in erratic, irrational ways. His aversive behavior put additional strain on the already troubled marriage. He came to therapy hoping to reduce anxiety and increase internal stability so he could restore harmony with his wife and save his marriage.

Lester was the youngest child in a large family. He recalled feeling lonely, anxious, and insecure throughout childhood but could not name experiences of physical or sexual abuse, threats, or trauma. He had a low Dissociative Experiences Scale (DES) score and was able to feel relaxed and calmed by the Light Stream Technique. I felt we had a green light to start EMDR.

He selected a disturbing memory of standing on the sidewalk in front of his house on his first day of school. He did not want to go. He was overwhelmed with separation anxiety. His mother stood on the front porch, waving him on. She expected him to walk himself to school, but he just wanted to run inside the house. A neighbor walked by, and his mom snickered that Lester was afraid to go to school. They both laughed at him. He felt humiliation on top of intense fear. At the start of EMDR, he rated the disturbance a 10. I was expecting a nice resolution, but that’s not what happened. Nothing got better, and he left my office feeling even more miserable. Three days later, he was admitted to a psych hospital with crippling anxiety. At the time, I had no idea what went wrong.

My Paradigm Shift

This experience I had with Lester, along with a few others like it, were a shock to me. I was still a fan of EMDR, but clearly I was missing something. I learned about resourcing and ego state therapy and began integrating them into my EMDR work. Even with that, endeavors to desensitize childhood wounding, like Lester’s, fell short. In 2000, I was thinking long and hard about why treating childhood wounds, like Lester’s, were so different from treating big T adulthood traumas. One day, I had a huge paradigm shift. I realized that many childhood wounds were less about bad things that happened and more about good things that didn’t happen. They were often not about traumas at all but about unmet developmental needs—especially unmet attachment needs. I came to believe, contrary to popular opinion, that not all wounding can be labeled trauma. Therefore, not all wounding will respond to traditional trauma treatment.

If attachment wounding comes from unmet attachment needs, I wondered if we could help clients get those needs met now. I began experimenting with needs-meeting interventions. I helped clients mobilize a team of loving, supportive, inner Resource parts of self and connected that team to attachment-wounded child ego states. As child parts got their emotional needs met by loving Resources, clients began to heal and grow. When I finally saw their unwanted behaviors, beliefs, and emotions begin to diminish, my ego state therapy model, the Developmental Needs Meeting Strategy (DNMS), was born.

The DNMS has evolved in many ways since 2000. It is now a multidimensional model with lots of protocols and interventions. This book does not cover the entire DNMS model, but it does teach a part of it that is useful for EMDR therapists. It will teach EMDR therapists how to:

- Differentiate attachment wounds from trauma wounds.
- Treat attachment wounds.
- Prepare attachment-wounded clients who also have trauma wounds for EMDR trauma work.
My Take on Childhood Wounding

This diagram of two overlapping circles provides an overview of how those of us wounded in childhood can have attachment wounds, trauma wounds, or both. The black circle on the left represents attachment wounding. The light gray circle on the right represents trauma wounding. The dark gray ellipse in the middle represents trauma and attachment wounding happening together. I elaborate on each type of wounding below. (See Chapter 3 for detailed case examples.)

Attachment Wounding: The black half-moon on the left side of the diagram represents childhood wounding from unmet emotional needs only. This wounding is always inflicted by primary caregivers like parents. This is wounding that poses no physical danger. It includes shaming, rejection, emotional neglect, enmeshment, chronic misattunement, disinterest, failure to repair breaks, and failure to meet emotional needs. It’s less about bad things that parents do to a child and more about important good things they fail to do.

Attachment wounding can happen when parents are able to comfort a child but fail to show loving delight, show loving delight but fail to comfort, or fail in both comfort and delight. As I see it, because there is no physical danger, this is not trauma wounding—not small t trauma, not relational trauma, not attachment trauma, and not complex PTSD. The severity of attachment wounding can range from mild to full-blown existential crisis. Severe attachment wounding brings anxiety, depression, emptiness, and intense despair. Attachment-wounded clients have many child ego states holding negative beliefs in reaction to hurtful messages. (Read about ego states in Chapter 2.) For treatment I’d recommend the DNMS ego state therapy interventions described in this book to meet the emotional needs of wounded child parts stuck in the attachment wounds.

Non-Caregiver Trauma Wounding: The light-gray half-moon on the right side of the diagram represents trauma wounding that’s unrelated to the child-parent relationship bond. That could include a nonrelational trauma, like a house fire, hurricane, or accidental injury, or a relational trauma, like a sexual assault from a teacher, priest, or babysitter. It could even include small t traumas like being bullied by a neighbor. For treatment I’d recommend EMDR when clients have sufficient foundational stability.

Caregiver Trauma+ Attachment Wounding: The dark-gray ellipse in the middle represents wounding from primary caregivers with a physical harm component, like physical or sexual threats or abuse or dangerous negligence, at the same time there’s attachment wounding, like parental shaming, rejection, emotional neglect, enmeshment, chronic misattunement, and failure to repair breaks. This leads to
**Complex PTSD** and foundational instability. The more severe the wounding, the more foundationally unstable a client will be and the more wounded child parts a client will have. For treatment I’d recommend DNMS ego state therapy for attachment wounds and, once clients are sufficiently stable, EMDR for trauma wounds.

**Non-Caregiver Trauma + Attachment Wounding:** Some clients have both attachment wounds (from the black half-moon side of the diagram) and trauma wounds (from the gray half-moon side of the diagram). In this case, a trauma is not inflicted directly or indirectly by primary caregivers, but caregiver failure to adequately address post-trauma needs compounds the wounding. For treatment I’d recommend DNMS ego state therapy for attachment wounds and, once clients are sufficiently stable, EMDR for trauma wounds.

**Foundational Stability versus Foundational Instability**

**Foundational stability** is self-love, self-confidence, and self-security. It’s an ability to stay grounded in the face of adversity and manage emotions in healthy ways. **Foundational instability** is self-loathing, self-doubt, emptiness, and emotional insecurity. It’s an inability to stay grounded in a crisis or manage emotions in healthy ways. We all fall somewhere on a continuum from very unstable to very stable.

Our degree of foundational stability is determined by neural architecture. The *amygdala* is the brain’s primitive threat detector, but it cannot distinguish between real and imagined threats. When it detects a danger, it may elicit a fight, flee, or freeze response. The *prefrontal cortex* is the seat of the brain’s executive functioning. It’s our most healthy, mature, wise, adult self, able to distinguish between real and imagined threats. When the amygdala perceives a threat, it signals the prefrontal cortex to assess the risk. If the prefrontal cortex receives the signal, it can calm a fear when there is no danger, or make a safety plan when there is. But it can only get the amygdala’s signal if a neural pathway links them.

We’re not born with this important neural pathway. It develops throughout childhood as loving, attuned caregivers meet our emotional needs, and repeatedly soothe our emotional upsets. As this neural pathway between the prefrontal cortex and the amygdala grows over time, foundational stability develops, giving us the ability to see danger clearly and regulate painful emotions.

But if we grow up feeling lonely, insecure, angry, fearful, or empty because unkind or misattuned caregivers are unwilling or unable to keep us safe or meet our emotional need, this neural pathway may fail to develop well enough. Our ability to see danger clearly and regulate emotions will be impaired. Furthermore, these painful experiences can lead to the formation of many wounded child ego states who are stuck in the past. These child parts persist into adulthood. They’re easily triggered, then struggle to self-soothe. They misperceive danger and overreact when they do. This is foundational instability. (Read about ego states in Chapter 2.)
Preparation with Childhood Wounding for EMDR

When foundationally stable adults have been destabilized by a traumatic event, EMDR can help them quickly restore their pre-trauma stability. But when foundationally unstable people are traumatized, they may have little or no stability to restore. We must assess a client’s degree of stability before beginning EMDR, then prepare them well.

Shapiro believed that most clients are stable enough for EMDR when they demonstrate: (1) a capacity for self-regulation; (2) an ability to maintain dual awareness while revisiting a disturbance, and (3) an ability to tolerate intense emotions. She believed we can prepare most clients to meet these criteria by helping them master relaxation or affect-regulation techniques such as Light Stream technique, guided imagery, meditation, progressive muscle relaxation, Safe/Calm Place, diaphragmatic breathing, or Andrew Leeds’ Resource Development and Installation (RDI). These state-change techniques are supposed to enable clients to modulate their emotional state so they can stay within their window of tolerance as painful emotions arise during trauma processing. (See the State Change versus Trait Change sidebar above.)

This client preparation approach works very well with foundationally stable clients, but what about our foundationally unstable clients, with lots of attachment wounds? This is what Shapiro wrote about preparing clients with Complex PTSD for EMDR.

- State-Change Problem: While foundationally stable clients can benefit from calming, state-change techniques, very foundationally unstable clients may not. A client’s adult self may be able to tolerate intense emotions during a self-regulation drill like Light Stream, but this does not ensure that wounded child parts, in the heat of trauma processing, can too. If wounded parts get triggered and panic during EMDR, it may be very difficult to calm them down. I’m certain that’s what happened to my client Lester. His wounded child parts became overwhelmed with fear and humiliation. I recommend seeking out wounded child to and stabilize them with trait-change interventions first, before processing trauma.
- **Defensiveness**: During EMDR, clients must be able to access traumatic memories without defensive actions like dissociation and avoidance. These defenses come from wounded child parts. I recommend seeking out child parts and to them until they no longer need to take defensive action. This will enable the adult self to tolerate the pain of remembering traumatic events.

- **Neural Architecture**: Foundationally stable clients who are overwhelmed by a trauma have temporarily lost access to their ability to manage emotions well. Shapiro rightly attributes this affect regulation loss to unprocessed trauma memories. But many foundationally unstable clients grew up feeling lonely, insecure, angry, fearful, or empty—not because of trauma but because caregivers failed to meet their emotional needs. Because of a weak amygdala/prefrontal cortex neural pathway, they’ve never been able to manage affect well. I recommend seeking out dysregulated wounded child parts to stabilize them in ways that strengthen the amygdala/prefrontal cortex neural pathway. This can lead to better emotion regulation, opening the door to successful EMDR processing.

- **Distinguishing Past from Present**: When foundationally stable clients are highly aroused by a trauma memory, they may temporarily struggle to distinguish past from present. Shapiro rightly attributes this difficulty to unprocessed memories. But foundationally unstable clients will have wounded child parts who’ve been stuck in their painful past since childhood. These parts have never been able to distinguish past from present. I recommend seeking them out, connecting them to loving Resources, and orienting them to present time so they can distinguish past from present. This can have an overall stabilizing effect which enables the adult self to stay in the present during trauma processing.

### Importance of Assessing Readiness

In my experience, the secret to assessing readiness for EMDR is to understand a client’s degree of foundational stability. We begin by getting a history focused on childhood relationships. (See Chapter 4.) This helps us discover how well attachment needs were met in childhood. As we get to know the client we determine how reactive she is. Is she easily triggered? Is it hard for her to self-soothe once triggered? This information can help us estimate the degree of amygdala/prefrontal cortex connection.

When we detect foundational instability, we could teach clients state-change techniques, or we could raise their level of stability with DNMS trait-change interventions. Chapters 10–14 teach interventions that help wounded child parts come into the present moment and form a loving bond with an internal Resource team. As their emotional needs get met by the Resources, the link between the amygdala and prefrontal cortex will strengthen, leading to increased stability.

If we underestimate a client’s degree of foundational instability and go ahead with EMDR, we may not get the expected outcome. Here are three examples of how that can happen.

- **The Obviously Unstable Client**: Clients who are easily overwhelmed, hurt, offended, and triggered often talk easily about the disturbing family-of-origin events that harmed them. If we believe their unprocessed memories are causing the affect dysregulation, starting EMDR right away is a logical choice. But if the instability is less about trauma wounds and more about attachment wounds, EMDR may fail to deliver the expected result. Even if the SUD comes down, processing may fail to lead to a meaningful reduction in unwanted behaviors, beliefs, emotions, and urges.

- **The Unstable Client Who Appears Stable**: Some clients are masterful at compartmentalizing or dissociating significantly wounding childhood experiences. Clients who function well in a challenging occupation, are good students, are competent caregivers, and/or report a happy childhood may appear stable. They may present with a single, adult-onset problem (like car accident flashbacks) or a single symptom (like complicated grief), adding to the impression of stability. Once trauma processing with ABS begins, dissociative barriers can weaken. This can awaken highly disturbing memories—surprising both us and them.
The Impatient Client: Some clients are impatient, so eager to get to emotional relief that we let them convince us they’re ready for trauma processing when we know they’re not. They’re often highly defended, determined to avoid the deep work they really need to do. They want a quick fix for something that cannot be quickly fixed. As a newly trained EMDR therapist, I had a young adult client who had endured a stranger rape. I worked with her for several sessions to get a good history and get her properly resourced. Each session she tried to convince me she was ready to process the rape. I was doubtful but could not pinpoint why. The longer I delayed, the more irritated she became. When it seemed she’d met all the preparation criteria and had a good enough Resource team in place, I suppressed my doubts and started reprocessing. Soon after beginning, she became overwhelmed, excused herself, and went to the bathroom to throw up. When she came back into the room, she did not want to resume EMDR or even talk about her experience. She left and never came back.

Other Factors Relevant to Treatment Success

The AIP model focuses exclusively on mental health problems that come from dysfunctional trauma memories stored in the brain, but other factors can play a role as well. For example, there are many maltreatment-driven neuroanatomical abnormalities that can develop when a child’s emotional needs and safety needs are not met well enough. Some abnormalities will impact our adult clients’ ability to manage painful emotions, independent of their disturbing memories. An elaboration of this topic is provided in Appendix A.

Some mental health struggles are less about trauma and attachment wounds and more about physical health. For example, symptoms like depression and anxiety can arise from genetic conditions, medical conditions, and medication side effects. You may be familiar with the mood-altering effects of sleep deprivation, thyroid disorders, menopause, vitamin deficiencies, and seasonal affective disorder. Poor intestinal health in the form of dysbiosis and leaky gut can also dysregulate emotions. An impaired gut microbiome has been linked to many mental health problems including anxiety, depression, alcohol cravings, eating disorders, psychotic disorders, attention-deficit/hyperactivity disorders, obsessive-compulsive disorders, and trauma-related disorders. An elaboration of this topic is provided in Appendix B.

If our treatment plan does not progress as expected, it may help to inquire about some of these other factors. In some cases, mental health issues may come entirely from poor conditions in the body. In other cases, poor conditions in the body may be hindering successful resolution from other treatment modalities.

Chapter 1 Summary

This chapter highlights the difference between trauma wounding and attachment wounding. In particular, how trauma wounding comes primarily from bad things that happened, while attachment wounding comes from important good things that didn’t happen. I introduce the concept of foundational stability and foundational instability. Foundational stability develops in childhood as attachment needs are met well and children learn to regulate their emotions. Foundational instability develops in childhood when attachment needs are not met well, and children fail to learn to regulate emotions. This can happen even when there’s been no trauma wounding at all. Foundationally stable clients who’ve experienced a trauma are great candidates for EMDR, because EMDR can quickly restore their pre-trauma stability. We can prepare foundationally unstable clients for EMDR by raising their level of emotional stability. We do that by helping wounded child parts get their emotional needs met now. This book explains how.
Notes

4. Also called Dual Attention Stimulation (DAS) or Bilateral Stimulation (BLS).