Using EMDR with Various Types of Developmental Trauma

by Morit Heitzler

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Complex trauma is based on underlying developmental trauma. However, developmental trauma is a very broad, non-specific category. There are several typologies and classification systems of developmental trauma available, with various degrees of usefulness to EMDR practitioners.

Having researched and assessed these different theories, in this workshop I will offer an integrative synthesis relevant to EMDR practitioners.

An understanding of the different types of developmental trauma can enhance our work both in terms of faster and more accurate diagnosis of developmental issues and also in eliciting relevant material and designing interventions. To establish key features of the client's developmental issues, we can use a holistic spectrum of physical, affective and cognitive factors, including the client's posture and body language, habitual cognitions and attitudes and modes of relating and expression.

Most developmental theories share a common view of the key factors of developmental trauma: the child's developmental stage, the intensity of the traumatising event, the available resources etc. But they vary greatly in terms of underlying meta-psychology and techniques and interventions.

Introduction:

I am here today to talk about developmental trauma. What comes to mind when I mention the phrase 'developmental trauma'? Abuse - physical or sexual, neglect, war, natural disaster. Indeed, all highly traumatic events or situations, which have been researched and studied in depth during the last 60 years. Today, however, I would like to address other forms of trauma, perhaps less dramatic in their presentation, but nevertheless as destructive and devastating in their impact. I will focus on a specific classification system of developmental trauma, originated by Wilhelm Reich, the founder of Body Psychotherapy and developed by his successors, Alexander Lowen, David Boadella and Stephen Johnson, to mention just a few. I will illustrate the theoretical part of my talk with a case study of one of my clients, to demonstrate how I applied some of the principles of developmental trauma in my work.

In his 1996 book, 'Somatic Stress', van der Kolk explains that "... trauma, especially prolonged trauma at the hands of people on whom one depends for nurturance and security, will significantly shape one's way of organizing one's internal schemes and ways of coping with external reality" (p. 201).

Today, I would like us to think of what constitutes 'prolonged trauma at the hands of people on whom one depends on'. To assist us with, that I will now present my client, Dora, and give you some vignettes of our work together.

Case Study 1

Dora was in her early 40's when she came to see me. Scottish in origin, she was the only member of her family who was living in England. She came to Oxford to study acupuncture and had intended to go back to Scotland two years later, after qualifying as an acupuncturist. Dora was single and had no children. She rented a room in a family home, worked part-time to support herself and studied hard. She was highly motivated and her life revolved around her course. Dora came to see me soon after having a panic attack during a practical class in which she was expected to treat a patient under the supervision of her teachers. This class is known as 'clinic' and I will use this phrase from now on.

Down-to-earth, solid and somewhat masculine in her appearance, Dora gave a reliable, responsible and capable impression. It was hard for me to connect the coherent, motivated, independent woman I saw in front of me with the panic, insecurity and shame that she was describing. Having come to this country myself to train as a body-centred psychotherapist, living away from my family and friends and supporting myself independently during my training, I was aware of some of the challenges Dora had to face on a daily basis. But as the session unfolded it became apparent that Dora met those challenges in a matter-of-fact, pragmatic way and did not view her lonely, hard-working life in a foreign country as a challenge. Her issue was of a different nature: Dora struggled with performance anxiety.

Being methodical and diligent in her studies, Dora possessed a good knowledge of the material she had learned, but when it came to display her knowledge in clinic or during exams, she experienced paralysing fear and was unable to function. She described how her body went rigid and cold and her mind went blank. She often failed her exams to the great surprise of her teachers, who knew her as an intelligent, competent, hard-working student. Dora's experience of herself was one of inadequacy and failure. For three years she tried to deal with it by herself, but her latest panic attack compelled her, as she put it, to give up and seek help, although this was not something that she really liked doing.
Sitting with Dora during the assessment session, I could imagine a straightforward EMDR process, in which we would build our connection and her resources, choose her experience at clinic as a target and process the anxiety through. However, something in Dora's presentation, perhaps her contempt of herself for having to ask for help in the first place, or perhaps the contradiction between her confident, capable appearance and the issue she presented, made me stop and re-consider. I asked Dora about her background and early years.

Dora was the fourth child in her family. She had four brothers, the youngest brother being a year younger than her, the oldest brother being 5 years older than her. Her father was often away on working trips, leaving her mother to manage the household and their 5 young kids. Dora remembered her parents as loving, devoting time to their children's education, but not showing any form of physical affection- to each other or to their kids. A lot of emphasis was placed on sport and Dora often played and competed with her brothers and their friends in various sports activities. She described herself as 'a good girl, quiet and hard-working', who did not have much affinity with other girls of her age, but was more of a tomboy. Her prevailing sense of herself was that she was not-good-enough and her brothers were better than her.

Dora's relationship with her mother was good, she said, if not very warm. Her mother grew up in a strict Victorian family. She herself had 9 siblings and her own mother was cold and harsh. Dora's mother wanted to train as an architect, but was not allowed to choose her career path as her parents insisted that she should become a secretary. When she married she had to give up her secretarial job in order to look after her children. Dora's voice was trembling with tears when she described her mother's disappointment. It was apparent that her mother's unfulfilled potential played a central role in Dora's determination to have a career as an independent woman. When Dora grew up, she studied engineering and graduated with honours, but after working for several years in a successful engineering firm she realised that her job was not fulfilling and decided to change her career.
She chose acupuncture, she told me, as it offered direct contact with people and an opportunity to help them where Western medicine had failed. Dora liked her acupuncture school and found it easy to make contact with some fellow students, although her best friends were always far away, some of them living in Scotland, some of them even further away.

As I listened to Dora's story, I had an image of a young, serious little girl, who was never hugged by her mother, who grew up amongst boys, competing for her place in the pack and never feeling good enough. I thought about her mother, growing up in a harsh, emotionally deprived household, whose only chance of approximating her potential was through her only daughter, and I tried to imagine that particular mother-and-daughter connection. Things were beginning to make sense.

Discussion 1

The central assumption of all branches of developmental psychology is that the first five years of human life are the most crucial in terms of moulding the psychological structure and personality. Latest neuroscience research has confirmed the significance of the mother-baby bond in forming healthy attachment patterns, which will enable the baby to tolerate rupture and repair, develop a sense of self, build resources for self-regulation and find an appropriate expression for his/her emotions.

One of the revolutionary aspects of this research is that it demonstrated that the emotional climate in the relationship with the primary caregiver affects not just the infant's psychology and mind, but it also significantly impacts on the anatomical and physiological development of the body, particularly the brain. Emotional interactions affect the structure of the brain as well as the brain chemistry, in terms of the infant's capacity for self-regulation and the containment of affect.

It is significant for all our work in the area of trauma, where physical, emotional and mental processes are so closely intertwined, to understand the developmental origins of these interconnections between body, feelings and mind.
This paradigm shift takes a third position beyond 'nature versus nurture' and is sometimes paraphrased as 'nature via nurture'. It has profound implications for our understanding of development, and therefore of developmental trauma. What scientists previously considered simply as anatomical growth spurts in brain development (i.e. neurons growing and interlinking to form connections), we now recognise them as 'developmental windows' which have corresponding manifestations both in terms of psychology and biology.

The first year of our lives is considered to be the most important and influential one, as in this year significant developments of the brain take place, mirroring the robustness of the primary bond. However, further development of the brain and of psychological structures takes place over the following 4 years, determining the child's capacity to engage with life in all its complexities.
During these first years the child goes through several developmental stages, growing from a helpless, needy baby to an independent, self-assertive toddler. Each developmental stage presents the growing infant with a task, the physical and psychological tasks complementing and correlating with each other. For example, at the age of around 15 months the developmental task is to develop the ability to separate from mother and begin to build an independent sense of self. This is also known as the 'rapprochement' stage. The toddler is able to walk independently, as his legs are now strong and developed enough to carry his weight, he is able to leave mother and go out on small adventures, exploring the fascinating world around him. Psychologically, the need to individuate allows the child to explore his existence away from mother, understanding slowly that *his* experience of the world might be different from that of his care-giver. Physically, his biological system supports the individuation task.
Each successfully completed developmental task builds another healthy psychological layer and the capacity for important capacities and functions, especially in relation to other people. Each developmental task successfully completed enables the child to move on, further developing his personality and patterns towards his full potential.
However, this process does not take place in a vacuum - on the contrary, it happens *within* a relationship, and it is these primary relationships that can determine the degree of its success or failure. To follow the rapprochement example, it is the mother's response to the toddler's emerging independence that will determine his sense of himself as a separate individual. If the mother is able to tolerate the separation and can support the child's adventures and explorations, he will be able to leave her and engage in his own activities, knowing that he can always come back to her, returning to the safety of their bond to share his discoveries and failures. That will give him the courage and security necessary for any further venturing into the world. He can leave her and come back, as her presence and love are solid and supportive of his separate existence. But if the mother is not able to bear the sense of separation and can not trust her child's ability to manage the world on his own, she might react by becoming over-protective, anxious and restrictive, concealing her own sense of abandonment under the guise of protecting her child. The child, then, will learn that the world is not a safe place and his mother can not exist without him. His spontaneous drive towards individuation and self-expression will go underground, as he will need to preserve the bond with his mother by 'being good' and adhering to her explicit and implicit wishes.

Over time, the child introjects mother's messages, and identifies with them. It is then no longer the external response to his impulses and drives that will determine his steps in the world, but the *internalised* mother, now part of his sense of self, his inner world and internal relationships. At the heart of the character that he will form, then, lies an internal conflict - 'the conflict between the irrepressible instinctual need and reaction, on the one hand, and the internalized blocking of these needs and reactions, on the other." (Johnson 1994 p.8). Since this conflict is unbearably painful and disturbing, the child will need to find a way to manage the ongoing pain. He does so by blocking and suppressing both the original impulse and the reaction to the frustration of that impulse. This often results in blocking his spontaneity, self-expression and creativity. On top of this suppressed conflict, the child then erects what Winnicott called the 'False Self' - an adaptation which carries within it some semblance of the suppressed conflict, but consists mostly of a compromise and submission to the environmental demands or an attempt to rebel against it.

I imagine that many of you are familiar with this way of thinking.
The question we now need to ask ourselves is: when is an environmental response to the child's developmental task a trauma-inducing response, and when is it a 'normal' socialisation response?
We know that the DSM IV defines traumatic incidents as; "Incidents that are, or are perceived as, threatening to one's own life or bodily integrity." (DSM IV 2000). This begs a further consideration: do we look at the experience from an adult external perspective or from the child's internal perspective? Do we measure the impact of the incident by the capacity of the child to adapt and present as well-functioning, or do we pay attention to the internal mechanisms the child had to employ in order to protect the bond with the care-giver, mechanisms like numbing, splitting, projecting and dissociating, which are part and parcel of trauma survivor's coping strategies? What would constitute a life-threatening incident from a child's perspective?

According to the theory of 'character formation' (Johnson 1994) it is not the frustration of the child's impulse that creates the ever-lasting chronic wound, but the systematic frustration of what he calls 'the organismic response'. He defines the organismic response as: "The natural, 'wired in' response to frustration by the environment - usually the experience and expression of intense negative affect, particularly rage, terror and grief at loss." (ibid p. 8).

Thus, if a child is faced with a frustration of an impulse, he can bear and regulate the frustration by expressing appropriate reactions like crying, shouting, kicking etc. If this reaction is met and contained by the parent, the child can complete a cycle of expression and integrate the frustrating event in his system, internalising its meaning (for example - I am not allowed to bite my baby sister although I really want to!) and carrying on with his life, feeling loved. But if his response to the frustration is not met, if he is not allowed to express his rage or fear, he is not allowed to cling to mother or scream at her, then, over time, the child attempts to preserve the life-giving bond with the parent leads him to internalise the negative response and block his impulses. Fairbairn (1974) explains how this results in unconscious and fixed internal object relations, resisting any new relationship, learning or change.

Returning to the question of trauma, I would argue that the *systematic* frustration of the child's attempt for self-regulation is experienced internally by the child as traumatic: the environment that he depends on is rejecting him, a rejection which is intolerable as it is experienced as a threat to his survival. He, therefore, needs to suppress and deny what Fairbairn calls his 'aggressive response' and practically 'kill off' a spontaneous part of himself.
This, in my view, is a traumatic process, as what is at stake for the child is experienced by him as an issue of survival and integrity of self. As in a trauma response, the child constructs his existence around the 'lessons' he learned, for example: "I can not show my rage". He is not able to allow any other relational experiences, as the past traumatic event colours and determines his position in the present.
All of us experience frustration and disappointments from a very young age and throughout life. Our psychological system is equipped to deal with these experiences. However, it is the *systematic* frustration, often accompanied with explicit or implicit treat of abandonment or physical pain that induces the trauma response.

Going back to Dora, I could track the foundation for the psychological structure she had erected back to what Reich named as the 'oral phase'. Dating roughly at the early age of six months, this is the phase in which the baby begins to make contact and build more of a relationship with the world around him, and most of all with mother. The baby's senses are developed enough to see, smell and react to the external world and he is ready to engage, using his own body's movements and voice, in expressing himself and playing. Parallel to that, other needs are also expressed more explicitly than before: the baby's lungs have developed enough to allow a loud cry when he is hungry, tired or uncomfortable. At this stage, the baby is totally dependent on his mother for all his physical and psychological needs and requires constant attention and care. The mother's role is to respond to the baby's demands and soothe his feelings by feeding him when he is hungry, picking him up and holding him when he cries, playing with him when he is energetic, helping him to calm down when he is tired. By doing this, she helps the baby in regulating his feeling and functions as a 'regulatory object' (Schore 1994, 2003).

However, if mother herself was not nourished enough during her childhood and her 'oral needs' were not met, she is likely to find it hard to attune to her baby's needs at this developmental stage. Indeed, Dora's mother believed that babies should not be spoilt, she therefore did not pick up her daughter when she cried in her cot, she fed her every four hours regardless of any signs of hunger or distress, and did not have much time or patience to play with her. Dora's mother loved her baby but was not comfortable with her own feelings, especially with her suppressed vulnerability and need. She expected her daughter to overcome her distress, as she herself did in relation to her harsh mother, and to become self-sufficient as soon as possible. When Dora was 7 months old, her mother realised that she was pregnant again. With her husband often away on work trips and having to care for four young children she felt drained and exhausted by her fifth pregnancy.

She grew more impatient and further withdrew attention from her daughter. Dora's cries of despair and rage were often met with further deprivation of contact leading to an excruciating sense of abandonment and loss. To survive, she had to negate her own needs and cut off from her instinctive reactions, she grew quiet and introspective. Mother was pleased and used Dora as an aid in looking after her brothers. Dora's confidence was never grounded in a healthy bond with her mother and therefore could not develop and she was always shy and withdrawn. Her only sense of worth stemmed from being a good student at school, but at home she constantly failed in being as boy-ish as her brothers. Since her femininity was not celebrated and mirrored by her mother, she felt estranged from other girls her age and kept competing for love by trying to be as sporty as her brothers, which led to a perpetual sense of failure, which she tried to conceal by trying even harder at school.

This was the developmental background that fostered Dora's character: she learned to contract *against* her need rather than reach out with it. She grew up to be self-sufficient and reliable, but deep within she was tormented by a chronic state of emotional hunger and despair.
It was against this background that the picture of another trauma began to emerge.

Case Study 2

Having unearthed Dora's developmental trauma and unresolved layer of rupture in her primal bond with mother, I introduced the concept of 'the inner child'. The next 5 sessions revolved around contacting and embracing the feelings, impulses and fantasies she had to repress in her early years. Dora enjoyed this re-union with the neglected part of herself and I could see how acknowledging and integrating those split-off parts was a necessary, empowering, resource-building stage of her process.

Soon after that we used EMDR to process a relatively 'light' incident of Dora's lack of confidence during an exam. It was quite a successful process as the SUD's went down from 8 to 4. Dora came back the following week reporting feelings of optimism, strength and more confidence in herself.

She then proceeded to tell me more about her teenage years and it slowly emerged that she was systematically bullied by her older brother, John. John was an angry, aggressive teenager who dominated the household with his mood swings. He was very attached to his mother and, like all his siblings, constantly competed for her attention. Dora was the focus of his outbursts of jealousy and rage, especially whenever she displayed a bond with the mother, or developed any closer connection with her which did not include him. Dora told me of an incident when she was trying on one of her mother's scarves and John kicked her legs and spat at her saying that she should wear her own ugly cloths and leave their mother's clothes alone. No adult was present at that time, but even if they had been, Dora said, it would not have made any difference to her, as her mother used to ignore the bullying and told Dora to not pay attention to John and get on with her own life.

Dora grew up accepting the constant beating, shouting and insults as if that was normal. She did not know any other way of dealing with it but to leave home and go for walks, "trying to forget about it" and hoping that by the time she came back John would have calmed down. As she was telling me this in the session, it was apparent that she had blamed herself for John's rage and aggression and that she did not expect any help and support with it. She conveyed these memories in a matter-of-fact tone and with an expressionless face - her attitude was that that was her lot and she had to get on with it. She was therefore genuinely surprised that I paid much attention to these incidents and took her feelings about them very seriously indeed. Her surprise grew even further when consequently she found herself remembering and sharing more and more stories of the aggressive, humiliating bullying. "I did not know that I remember it all", she said, "I thought I had put it behind me."

Dora was then ready to acknowledge for the first time that these incidents were not just a result of John having 'a bad day', but an ongoing, daily reality, which she had had to somehow survive on her own.
When we processed a major incident of bullying with EMDR, the main difficult feeling that emerged was not fear or rage, although those feelings were definitely present. Significantly, the main feeling which constituted an eye of a needle through which all other feelings were conditioned and mitigated was that of being unprotected, alone, with nobody to support and defend her. It was during our work with those feelings, central to Dora's sense of her childhood and the image she developed of herself in the world, that she was able to make the link between her current panic attacks and her childhood experience. It was that sense of being on her own, having to 'get on with it' when feeling helpless and terrified that paralysed her during exams and in class, where she expected to be humiliated and degraded. Unable to reach out for help, or even name what was happening, younger and older parts of herself re-lived that same sense of panic and attempted to deal with it by numbing and splitting off, as she had always done.
It was only when we were able to process and work through the inability to ask for help and the denied vulnerability and need, that Dora was able to feel differently during exams or clinic. It was a long and slow process, as it required the undoing of both physical and psychological defences and patterns, re-visiting and understanding her early coping strategies in the face of what had felt to her like unbearable pain and despair. Dora's disbelief and difficulty in receiving help and care were mirrored, unavoidably, in our relationship, and a significant part of the work took place in that relational arena. As we gradually were able to process the childhood trauma, Dora gained more strength and as she was able to own and express her vulnerability, her confidence grew. We then worked with EMDR and processed the residue of bullying and neglect she still carried in her system. I was happy to see all SUD's going down to 0, but the great moment of triumph we shared was when before her final exam Dora said: "Yes, I am scared, it is normal to be scared before such a big exam, but I think I will be alright, I studied hard and I know my stuff, and besides, I have you by my side!"

Discussion 2

Understanding Dora's developmental trauma and her characterological defences was key to her healing process. What do you think would have happened if I had not addressed the deeper developmental trauma and went straight ahead into processing the symptom she displayed: her performance anxiety?
And even then: what would have happened if only processing the later bullying without addressing the earlier sense of abandonment and resulting burden of self-sufficiency ?

I was mulling this question over in my mind when I remembered Mark Dworkin's words: "Any EMDR clinician can tell you that when you use a target memory to stimulate a memory network, other memories associated with the target can emerge." (Dworkin 2005 p.8).

I assume that processing the paralysing anxiety Dora felt when asked to perform in clinic would stimulate a memory network that would lead back to her anxiety at home, when she was not able to perform better than her brothers and expected humiliation. Perhaps it would have also led us back to the perpetual bullying at the hands of her brother. But would it lead us to the *source* of her anxiety?

Dora's anxiety originated in her insufficient bonding with her mother. The systematic frustration of her developmental need undermined her confidence both in mother and in the world, creating a pervasive undercurrent of anxiety in her system. She was not able to master the basic processes of self-regulation, as her attempt to do so were met with what felt to her at the time as further threats to her existence. Her survival strategy was based on withdrawal, numbing of emotions and an enforced self-sufficiency based on being under-demanding and undemanding. From her solid physical and rather masculine build to her mental idealisation of self-sufficiency, Dora's bodymind reflected both the trauma and the defences against it. This trauma and its consequences constituted the foundation, the lens through which later childhood events were interpreted and understood. The constant competition with her brothers, her second-grade identity as the only girl in the pack and the ongoing bullying were all an outcome and a manifestation of her earlier, primal wound. Therefore, understanding the centrality of the developmental trauma was crucial to our work.

Bringing the relationship with her mother into Dora's awareness and working through the unexpressed feelings and impulses was, in my opinion, an integral part of the EMDR process we embarked upon. My inclination was to work with her 'inner child', using an integration of body psychotherapy, guided imagery, gestalt dialogue and relational psychotherapy. These are methods and approaches that I am comfortable working with, but I am by no means suggesting that they constitute the only one or correct way of working with childhood trauma. Whether or not we choose EMDR to process an early developmental wound, I would argue that understanding and working with those character forming dynamics is both essential and vital to our work.

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