Healing the Caregiving System: Working With Parents Within a Comprehensive EMDR Treatment

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This article is an excerpt from the book *EMDR Therapy and Adjunct Approaches With Children: Complex Trauma, Attachment, and Dissociation*. It presents an original model to work with caregivers of children with complex trauma. This model comprises 3 levels of parental involvement within a comprehensive eye movement desensitization and reprocessing (EMDR) treatment: psychoeducation, self-regulation, and memory reprocessing and integration (Gomez, 2009, 2012a, 2012b). Mentalization and reflective function (Fonagy & Target, 1997), mindsight (Siegel, 1999, 2010), mind-mindedness (Meins, Fernyhough, Fradley, & Tuckey, 2002), insightfulness (Koren-Karie, Oppenheim, Dolev, Sher, & Etziom-Carasso, 2002), and metacognitive monitoring (Flavell, 1979; Main, 1991) are all constructs linked to the parent's capacity to develop infant's attachment security. However, unresolved trauma and loss appears to impair these capacities in parents. Many children wounded by caregivers lacking such competences had to endure repetitive emotional, physical, and sexual overt and covert abuse; enmeshment and intrusiveness; or on the contrary, detachment and lack of connection. When the caregivers have been the wounding agents, their inclusion and active participation in the overall treatment of their children is fundamental.

Keywords: caregiving system; mentalization; contingency; connection; differentiation; regulation

The inclusion of parents and caregivers throughout the eight phases of eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001) is essential for best treatment outcome with highly traumatized and internally disorganized children. "Parental responses serve both to amplify and reinforce an infant's positive emotional states and to attenuate the infant's negative emotional states. These repetitive experiences become encoded in procedural memory" (Kandel, 2006, p. 374). For children where the parent has been the wounding agent, these recurring injuring experiences provided by the caregiver on a daily basis, could continue to reinforce and shape neural systems. Trying to process and integrate these maladaptive neural networks while the caregiver constantly reinforces them could affect the overall EMDR treatment outcome. According to George and Solomon (2008), the development of the caregiving system and the resulting caregiving behaviors is the product of complex transactions between biological and experiential factors. Specifically, when working with children with disorganized attachment and dissociative tendencies, understanding the "disabled caregiving system" (George & Solomon, 2008) is necessary. These authors have proposed that the caregiving system of disorganized children is characterized by failures of protection, relinquished caregiving, and helplessness. When working with children of parents with abdicated caregiving systems, repetitive daily parent–child interactions can continue to enhance maladaptation. Moreover, frequent negative and dysregulated interactions with the caregiver will maintain the child in a constant state of internal activation. When the child stays in persistent states of hyper- or hypoarousal, these states will become sensitized and eventually will become traits (Perry, 2009).

Parental stress, depression, psychopathology, and lack of appropriate support have been identified as

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important factors that influence the quality of parental care. It is also important to highlight that the parent's current caregiving difficulties not only may be rooted in his or her own unresolved past attachment trauma and loss, but also in current experiences of distress. Lyons-Ruth and Jacobvitz (2008) were unable to differentiate between organized and disorganized groups of infants while interacting with their mothers under low-stress conditions. However, under stress, even parents with an earned-secure category in the Adult Attachment Interview (AAI) can develop attachment disorganization in their children. According to the adaptive information processing (AIP) model, present stressful situations can serve as the activating stimuli that bring these memory networks of early attachment traumas back to a state of activation. When these networks are activated, it causes the individual to act in ways that are more consistent with the past than with the present (Shapiro, 2001).

Many researchers have singled out the mother's perception of the infant and their relationships as the most relevant factor that influences parental care (e.g., Bokhost et al., 2003). According to George and Solomon (2008), the mother's awareness and view of the infant and their relationships is heavily affected by the mother's own memories and feelings about her own attachment experiences. As presented by Sroufe, Egeland, Carlson, and Collins (2005), it is important to highlight that parenting behaviors are not static and they actually change in response to the child's developmental stages. In addition, each child may elicit different parental responses in each parent or caregiver. Sroufe, in her clinical observations, noticed certain patterns of sexualized seductive parenting behaviors exhibited by mothers with history of sexual abuse or sexual exploitation (Sroufe & Ward, 1980). These parental behaviors were not observed toward all the children of the same parent and they also seem to be present only when the infant or child did not follow through with the requests of the parent. Similar observations were made in parents that engaged in physical abuse. Several important aspects were observed that are worth highlighting: First, the sexualized care was only triggered by the male infant or child. Second, it was elicited when the parent experienced stress and was unsuccessful in getting the child to comply. Third, the parental behaviors, whether sexualized or physically abusive, tended to escalate as the parent's level of stress increased, starting with subtle displays to more marked overt displays (Sroufe & Ward, 1980). Looking at these findings through the AIP perspective (Shapiro, 2001), we see how the child's behavior, gender, or temperament at different developmental stages have the potential to activate the memory networks containing the parent's early experiences of either sexual or physical abuse. In the case of parents exhibiting sensualized parenting behaviors, the infant's gender and response that stressed the mother seemed to serve as the activating agent. It is worth noting how each infant's prenatal experiences and genetic makeup will result in the newborn's overall temperament. The characteristics and temperament of the infant, in turn, may activate different memory systems of the parent, resulting in potentially dysfunctional parent–child interactions.

The following case illustrates this point: A 5-year-old girl was brought to counseling because of her frequent temper tantrums when she was not given what she wanted. The mother described the child as manipulative and defiant. According to the mother, this child was very difficult to soothe since she was a baby and was colicky for the first 6 months of her life. Her oldest daughter, on the other hand, was described as a very quiet and compliant child. Even as an infant, she was quiet and easy to soothe. When a more thorough assessment was performed, the mother was able to identify negative beliefs, emotions, and bodily states associated with the behaviors of her child. The mother stated that she felt out of control and thought that she was an incompetent mother. Her history revealed experiences of separation from her biological parents and rejection and neglect from her adoptive parents. We can see how the temperament of the youngest child had the potential to activate the mother's memory systems containing the information of her unresolved adverse attachment experiences. When this mother was asked to describe the responses she had toward her child when she was exhibiting temper tantrums, she stated that at times she spanked her repeatedly, yelled at her, and other times she just locked herself in her room while her child continued to scream outside her door. The unresolved trauma and adversity of the mother clouded the mother's capacity to attune to the child's needs and respond contingently. The child's current needs and behaviors were seen, interpreted, and experienced by the parent through the lenses of unintegrated and unresolved memories. It is worth highlighting that the abusive and rejecting behaviors from the mother were only elicited when the mother was unable to soothe the child, and her responses escalated as the child continued to challenge the mother's regulatory capacities. The oldest child, however, did not elicit such responses even as an infant because of her calm temperament. These memory networks that remain in a latent state, in the absence of triggering events, most likely will remain deactivated. However,

it will be almost impossible to have a life free of triggers and environmental stimuli that once again hold the power to bring these memory networks back to a state of activation.

Moreover, parental responses that create dysregulation in the child's system also appear to be related to the parent's capacity to reflect, represent, and give meaning to the child's internal world. Studies looking at maternal insightfulness have yielded information regarding the extent to which parental insight into the child's point of view and mind is predictive of infant attachment.

A study conducted by Koren-Karie, Oppenheim, Dolev, Sher, and Etziom-Carasso (2002) assessed the insightfulness of 129 mothers of 12-month-old infants. The mothers watched videotapes of their infants and themselves. Later on, the mothers were interviewed about their own thoughts and feelings as well as their own subjective experiences of the thoughts and emotions of their infants. The findings show that mother's insightfulness was associated with sensitive parenting and infant attachment security. This refers, according to Fonagy and Target (1997) to "the caregiver's capacity to hold the child's mind in mind." Sleed and Fonagy (2010) have proposed a link between the parent's state of mind regarding his or her own attachment experiences, the parent's responses and interactions with the child, and the parent's capacity to represent the mind of the infant. The activation of the parent's attachment memories seems to interfere with his or her capacity to understand and resonate with the mind of the infant. In other words, the parent's state of mind—with respect to his or her own attachment history—may directly affect his or her ability to create an organized, coherent, cohesive, and integrated subjective experience and view of the infant/child and a subsequent narrative. The resulting parent's representations of the child's mind may directly affect the contingency and congruency of the parent's interactions and responses toward the child.

A striking finding in the study of Ainsworth, Blehar, Waters, and Walls (1978) showed how babies that ended up developing avoidant patterns of attachment with their mothers were held as often as other infants. However, the mothers of these infants did not hold them when the infants actually showed signals of wanting to be held. The Ainsworth team observed how these mothers actually distanced and turned away when the infant showed them explicitly that they wanted to be hugged or picked up. A viable hypothesis considering how these mothers may have had dismissing states of mind regarding their own attachment histories is that the neediness of the baby actually activated the memories of early maladaptive attachment experiences. In addition, the strategies used by these mothers in response to the lack of emotional availability of their own caregivers would have once again become activated by the infant's responses. In the Minnesota longitudinal study (Sroufe et al., 2005), it was found that the caregiver's psychological understanding of the infant was a strong predictor of the quality of parental care. Some caregivers failed to understand the needs of their infants and perceived them as "needy." Other mothers failed to perceive their infants as an autonomous being and saw them as responsible for meeting the parent's needs. Two important variables were found to be significant in the quality of parental care: the capacity to understand and perceive the infant as a separate being and the capacity to perceive the infant as a being in need of care.

Another aspect that is worth exploring is the potentially detrimental effect of exposing infants and children to conflicting and contradictory representations of the self and the parent. According to Liotti (2009),

> parental communications that are frightened or confused, but not obviously maltreatment of the infant may set dissociative mental processes into motion. Pathological dissociation, in infancy, is a primary failure in organizing multiple and incongruent models of the self and other into unitary mental states and coherent behavioral states rather than an intrapsychic defense against unbearable pain of severely traumatic experiences. (p. 56)

These confusing, incongruent, and disorganizing parental behaviors may be the result of behaviors that are set in motion by the activation of neural networks containing information about the unresolved trauma and loss of the caregiver. As long as the caregiver's memory systems remain unprocessed and unintegrated, the child may continue to be exposed to the same experiences that laid the foundation for the development of dissociative mechanisms.

Based on all the cited findings and constructs, the work with caregivers and parents of insecurely attached, dissociative, and traumatized children is pivotal. Assisting caregivers in developing the capacity for mentalization (Fonagy & Target, 1997), mind-mindedness (Meins, Fernyhough, Fradley, & Tuckey, 2002), mindsight (Siegel, 2010), insightfulness (Koren-Karie et al., 2001), and metacognitive monitoring abilities (Flavell, 1979; Main, 1991)—all of which are constructs linked to infant's development of attachment security—is fundamental.

We can conclude that parents' coherence of mind regarding their own attachment experiences is linked to parents' narrative coherence of the infant's world. To promote the parent's ability to have insight, reflective functioning, empathy, and ultimately, coherence of mind, the parent's past unresolved attachment experiences, traumas, and losses will need to be integrated, assimilated, and moved to an adaptive resolution.

One of the fundamental goals of EMDR therapy is to promote integration and synthesis of neural systems. When we become integrated and achieve greater levels of completeness within ourselves, we get to fully embrace who we are; and as a result, we are able to fully embrace and resonate with others. According to Siegel (2010), "Resonance requires that we remain differentiated—that we know who we are—while also becoming linked" (p. 63). As stated early, parents with insecure states of mind may achieve differentiation, but are unable to connect and link with their children, and as a result, strongly promote premature independence. Other parents are unable to become differentiated and may fail to perceive their children as separate organisms, resulting in enmeshed parent–child relationships.

The participation of caregivers of children with experiences of trauma and adversity occurring within the caregiving system is critical. The question remains, as to when and how to do the work with caregivers within EMDR therapy.

Even though the work with caregivers is heavily initiated during the preparation phase, it should continue throughout the eight phases of EMDR therapy. Stabilization of the caregivers and the family system greatly expands the child's internal sense of safety, containment, and regulation. Promoting change in the dysfunctional and dysregulated family interactions can be addressed at different levels within the eight phases of EMDR therapy. Parents come with different ideas and expectations about therapy and their own involvement in the child's healing process. Some parents want to clean up the house, some are willing to clean up a room, and some just want to clean up a table. With this in mind, expectations about treatment should be clarified early on. The level of participation may vary depending on the needs of the child and the willingness of the caregivers to be an active participant. Using an honoring, caring, and respectful approach, the clinician should promote accountability and participation on the caregiver's side. In my view, three potential levels of involvement and intervention with caregivers may be appropriate. Keep in mind that appropriate consents should be obtained regarding providing direct interventions with caregivers. In addition, clarification on who will be the primary client—in this case the child—should be openly discussed. Information leading to the caregiver being able to provide informed consent should be furnished. It may also include the involvement of another clinician that can directly work with one or both parents. If this is the case, close communication among clinicians should be maintained.

Some parents may need only psychoeducation to promote change in the parent–child maladaptive interactions. Other parents will need to work on improving their ability for affect regulation, in addition to receiving psychoeducation. However, for best treatment outcome, most parents of dissociated, fragmented, and insecurely attached children will need to reprocess the memory networks associated with their own attachment traumas and injuries that continue to cloud their perceptions and responses toward the child. As long as the parent continues to enhance multiple and incongruent mental models about the self and others, the integration of the child's memory networks might be compromised.

During Phase 1 of EMDR therapy, the AAI represents a very powerful instrument for EMDR clinicians when working with complex trauma cases. If parents are unable to promote attachment security in their children because of the presence of dismissing, preoccupied, or unresolved states of mind, the work with the child may be slowed down or compromised. Considering that the administration of the AAI takes between 60–90 min, it could easily be incorporated as part of the initial history taking of EMDR therapy. It may save a lot of time and effort to clearly delineate the dyadic interactions and the specific attachment patterns of the child with each parent and the states of mind of the caregiver regarding attachment experiences.

Deciding on when and how much to include the parent in treatment is always a complex question and decision. For the most part, when children exhibit symptoms or have difficulties connected to trauma, adversity, or chaos originating within the parent–child relationship, the parents should be included as much as possible. The parent's choice to partake at one of the levels of participation delineated in this chapter should be foremost honored. However, enough information regarding the benefits and pitfalls of fully participating or completely withholding participation should be openly and gently discussed with the parents. With this information, the parent can ultimately make an informed decision of the short- and long-term potential consequences.

Level I: Psychoeducation

Helping parents arrive at a deeper level of understanding of their parental role using the AIP model, attachment theory, regulation theory, and interpersonal neurobiology principals will create a solid foundation. Providing the information in a simple and easy-to-understand manner is fundamental. Metaphors and analogies are helpful when presenting information that otherwise could be foreign and dense to the average parent. It is important to emphasize how metaphors are also the language of the right hemisphere. Keeping in mind the ultimate purpose of assisting parents in developing a deeper and clearer understanding of their parental role will assist you in finding the best way of conveying this information. The following are analogies that may assist parents in achieving this goal. These analogies also have facts and theoretical constructs that can engage the left hemisphere. These, however, are not the only ways to convey this information; in fact, some parents may respond better to a more linear factual explanation. If that is the case, provide information on current literature from attachment theory, neurosciences, and AIP.

The Mirror Analogy: Understanding Basic Principles of Attachment Theory and Adaptive Information Processing

This analogy is intended to assist parents in understanding how the child's sense of self does not develop in isolation but through the repetitive interactions with important attachment figures. It helps parents bring awareness to the current dyadic exchanges with their children that may be enhancing adaptive or maladaptive memory networks. Say, *"When we come into this world, we have a brain, a body and a nervous system ready to be shaped by experience and the environment it encounters. At this time, we have all the ingredients to form a sense of self, but we need experiences from those closest to us to form and develop a conscious sense of self because we do not have one yet. It is like the parent has a mirror in front, and we can see the reflection of the self through this mirror."* Place a real mirror in front of your chest, facing the caregiver. *"Through this mirror, we learn if we are good or bad or if we are lovable or unlovable. Our parents' words, actions, internal states, facial expressions, presence or absence, mirror who we are and what we are worthy of in life. Each experience is encoded in the child's brain and also in the parent's brain. These mirror experiences form files in the child's brain that contain all the information about the self, the parent, and the world. These files are usually locked, unless something or someone in our environment opens them up. When these files are opened or activated, all the emotions, bodily sensations, and beliefs about ourselves are also in a state of activation. This causes us to have emotions, thoughts, and bodily sensations in the present that are reminiscent of the past experiences we had with important mirror figures in our lives. In other words, the past can continue to shape how we respond to the present and, ultimately, how we shape our future. With this being said, I would like you to take a minute to just notice what your child may see on this mirror on a daily basis. Can you think of what you say or do or what your nonverbal signals communicate to your child? What do you think your child needs to see, feel, or hear about himself or herself? What did your child receive early on from you and others to form files about the self, about you, and about the world?"*

Establish a clinical landscape of the parenting behaviors and interactions that promote the development of a positive healthy sense of self as well as a sense of internal regulation. On the other hand, include the parenting behaviors that promote disorganized, avoidant, or anxious attachment patterns and ultimately dysregulation of the child's system. In addition, even parents that are capable of promoting attachment security in their children may have had experienced adversity and trauma. They may show coherence of mind when discussing these experiences; and in the view of the AAI, this may be a sign of resolution of these experiences. It is important to keep in mind that the AAI does not look at the level of disturbance associated with these memories; instead, it looks at the coherence of mind and of the narrative when exploring these experiences (Hesse, 2008). A parent categorized as having secure-autonomous state of mind regarding attachment experiences may have memories that still hold disturbance and, as a result, have the potential of being activated in the present by the child's behaviors or other stressors. Helping the parent understand how the neural networks containing adaptive and maladaptive experiences are the cornerstones and mediators of the way they are parenting and responding to the child in the present is fundamental.

An important aspect of securely attached dyads is the capacity of the caregiver to repair moments of rupture in the parent–child daily interactions. According to Schore (2009), the capacity of the parent to reattune in a timely manner, after having moments of misattunement will result in positive states of arousal and the modulation of negative arousal. Helping the parent recognize moments of misattunement and the importance of timely repair should be part of the initial stages of treatment with caregivers.

Teaching Parents How to Parent From the Adaptive Information Processing and Attachment Perspective

Most parents bring their children to therapy with the vision of changing them. According to Forbes (2009), the question parents must ask themselves should be: "How can I understand my child and my child's unmet needs?" instead of "How can I change my child's behavior?" Stimulating the parents' curiosity and motivation to get to know the child at a deeper level should be promoted. Biological and adoptive parents of children with severe dysregulation of the affective system get often to the point of restraining, yelling, and distancing from these children, thus increasing the children's level of isolation and disconnection from the parent. It is a difficult task for a parent to promote a healthy bond with a child that engages in what I call "pushing" and "pulling" behaviors. "I want you close, but get away from me," is the constant message these parents receive from their children. These behaviors often seen in children with attachment traumas and reactive attachment disorder (RAD) could be extremely difficult to manage. Very often, this is connected to a great dilemma these children endure: the fact that the caregiver activates the attachment system and the defense system simultaneously (Liotti, 2009; Main, 1995; Schore, 2009). The person that the child's survival depends on is the same person that activates animal defenses. Staying present, while resonating through love and acceptance, with appropriate boundaries, is the key to success when the child has these two systems activated. When working with adoptive parents, explain how when past caregivers exhibited frightening or frightened behaviors, the child experienced these caregivers as a source of fear and danger. As a result, the child's defense system was stimulated causing the child to want to fight or run away from the parent. The child, unable to escape the source of danger, opted for surrendering and potentially going into trance like states that seem to be the beginning of the development of dissociative responses (Liotti, 2009). Another system that was also stimulated by these parents was the attachment system. This system is organized to ensure that the child's needs for connection and ultimately survival are met. Now, when the new parent attempts to get close, set a boundary or care for this child; activation of neural systems that hold the information about past dysfunctional parent–child attachment interactions is inevitable. When these neural systems are activated, the animal defenses, along with conflicting biological forces that drive the child to seek proximity, get entangled. When parents learn to recognize that their child is not bad, evil or damaged, as many desperate parents come to believe, but instead they learn to recognize their pain and the deep and profound injuries, healing can begin. When presenting this information to biological parents that have been the actual source of fear and danger to the child, caution should be used. It is important to encourage healthy accountability without triggering guilt and shame. Holding this information until the parent is at a place where this material can be shared may be appropriate. In addition, teaching parents "reflective communication" and "mirroring" communication is pivotal. For children with attachment injuries and dissociative tendencies, having caregivers and other important people in their lives provide a communication that help them feel seen, heard, and felt will promote the development of a coherent representation of the self and other. If the child is happy, mirror this experience by saying: *"I notice that when dad told you to play cars, your eyes got really big and bright and right away you got this big smile. I can see how playing cars with dad makes you really happy. Do you notice/see that?"* Another example may be: *"I notice that your face got really sad and your eyes and smile got really small. I can tell that when your friends don't play with you at school, you get really sad. I am right here with you and we don't need to be sad alone. I am right here with you and your sad feelings. We can do things together to help the sad feelings or I can help you find something you may do on your own to help the sad feelings as well."* Some parents may have great difficulty mirroring the child and without the integration of their own past memories of trauma and adversity, their capacity to mirror and mentalize may continue to be compromised.

Level II: Self-Regulation

An important goal of the preparation phase of EMDR therapy is to assist parents in developing the ability to regulate themselves and their children. According to Schore (2010), "Attachment is the regulation of interactive synchrony" (p. 21). Parent–child interactions conducive of attachment security show the presence of affect synchrony that creates positive states of arousal and interactive repair. These two processes ultimately result in the development of self-regulation (Schore, 2010). However, children growing up in stress-provoking and affectively impoverished environments already exhibit pervasive affect dysregulation. If the child continues to interact on a daily basis with a caregiver who exhibits interactive asynchrony, the future may not be a promising one. These cases may require extensive and direct work

with the caregiver or the parent. Enhancing existing resources, developing new resources, and ultimately helping parents access and use these resources when in the presence of the child's activating behaviors is critical at this stage of treatment. This level of intervention within a comprehensive EMDR treatment includes teaching parents relaxation skills; grounding exercises; boundaries; mindfulness; calm, safe place; and Resource Development and Installation (RDI). It also involves exercises geared toward assisting the parent in developing or enhancing the capacity for attunement, empathy, emotional connection, affective communication, and reflective functioning. If the child's clinician is the one working with the parent at this level, appropriate consents should be signed. In addition, proper information should be provided to assist the parents in making and informed decision. At this point, a referral can also be made to another EMDR clinician.

Relaxation and Grounding Exercises

Parents of children with pervasive dysregulation of the affective system face the daily challenge of parenting these children. Relaxation exercises such as the light stream (Shapiro, 2001), progressive muscle relaxation (Jacobson, 1938), visualization, and imagery exercises where the caregiver finds a place of peace and comfort can be very beneficial. Oftentimes, parents need grounding exercises and can benefit from attending yoga classes. Encouraging the parents to include physical exercise in their daily routine as well as to teach them mindfulness, will be helpful.

Developing Boundaries

Bringing awareness to the parents' personal boundaries is extremely relevant. How can parents recognize the boundaries of others and teach their children about their personal space if they cannot recognize their own? How can we develop a coherent and cohesive sense of self if our own sense of space and boundaries are not acknowledged? In my clinical experience, parents with insecure states of mind regarding their own attachment experiences tend to have a very poor sense of their own boundaries. These parents may violate the child's boundaries by becoming intrusive and enmeshed, as it usually happens with parents with preoccupied states of mind. On the contrary, parents with dismissing states of mind may violate boundaries by being too distant. The parent with unresolved states of mind may violate boundaries by engaging in frightening or frightened behaviors. At times, the child may experience the parent as being too intrusive and, at times, as being too distant and detached. Educating parents about how we develop our sense of personal boundaries should be done during the preparation phase. If parent–child interactions are marked by boundary violations, the child's process of individuation is constricted and thwarted. Depending on the parents' current state of mind regarding trauma, loss, and attachment experiences, specific sets of challenges and strengths may be present. When working with boundaries, assisting the parent in identifying boundary tendencies is usually helpful. In addition, identifying the driving forces of parental responses is relevant. For instance, a 12-year-old child who was exhibiting extreme anger toward his mother stated that he felt smothered by the level of closeness from his mother as well as the uninvited physical expressions of nurturance. I asked the caregiver to focus on the moment of wanting to hug her child while noticing whose needs were being fulfilled at this moment. The mother responded that she was the one who actually needed the hug. The mother was actually very sincere in telling me that she wanted to experience the same feelings she used to have when her father held her. The mother, in fact, reported that she believed that children were supposed to meet their parents' needs. She added that this was a clear message she had received as a child by both of her parents, mostly her father.

Developing Resources

The use of the calm, safe place and RDI protocols can help parents expand their ability to tolerate and modulate affect. Not only is the RDI protocol (Korn & Leeds, 2002) an excellent way to help parents develop resources, but it also enhances the parents' ability to utilize them in the presence of the child's triggering behaviors. Before initiating RDI, it is important to identify the parenting behaviors interfering in the development of healthy parent–child interactions. Needless to say, if abusive parenting behaviors are present, appropriate measures should be taken to correct and report this situation to child protective services.

These ineffective parenting behaviors most likely are the result of how the parent was shaped by environmental and attachment experiences. In addition, the parent's response could be seen through the AIP model as the manifestation of early maladaptive experiences that are most likely encoded in the brain at an implicit level (Shapiro, 2001). As a result of the implicit nature of these memories, the parent may not have a subjective experience of remembering (Siegel, 1999) when this information is elicited by current stimuli.

With this in mind, assisting the parent in identifying the current triggers and the past experiences that are setting in motion the current dysfunctional parenting responses can help the parent link the past with the present. Assisting parents in making this information available to their conscious awareness is an important step toward integration. For parents with severe affect dysregulation, appropriate stabilization should be attained before exploring triggers and experiential contributors. In addition, the presence of dissociation should be assessed and ruled out before initiating RDI and addressing attachment traumas and injuries. If extensive trauma exist, a referral to another EMDR clinician that can maintain close communication with the child's therapist should be made.

Level III: Memory Reprocessing and Integration

When the different levels of intervention are presented to the parents, they may think that this third level may be too costly or too long. In my clinical experience, in the long run, not providing the best form of treatment in the present has the potential to end up costing more, lasting longer, and being less effective. In addition, the clinician should emphasize the great plasticity of the developing brain of the child and the importance of early intervention in promoting mental and emotional health.

This level of intervention is extremely relevant for parents of dissociative children. According to Liotti's (2006) etiological model of dissociation, a child's pathway into dissociation begins with the formation of disorganized attachment with the primary caregiver. However, even when a pattern of attachment disorganization already exists, full mental health may be accomplished if the primary caregiver achieves an organized state of mind regarding his or her own attachment experiences. To that end, the third level of intervention with parents within a comprehensive EMDR treatment involves the reprocessing of the experiential contributors to problematic parenting. Helping the parent attain some level of integration and internal organization will in turn help the child develop unitary and more congruent models of the self and others. Appropriate stabilization of the caregiver to the point of achieving an adequate level of affect tolerance should be attained. The appropriate assessment and exploration of dissociative experiences should be carefully done. It is extremely important to stay within your level of clinical expertise. Some child EMDR clinicians may not have expertise in working with highly dissociative adults. Appropriate referrals should be provided to the parent to see a more qualified EMDR clinician. However, communication between the parent's treating clinician and the child's therapist should be maintained for best treatment outcome. Needless to say, appropriate consents to share information should be obtained. In addition, the child's EMDR clinician should review state board rules and regulations for working with parents before attempting to work directly with the child's parent. If both parents have agreed to receive treatment, they each should work with a different EMDR clinician to avoid conflict of interest, while they maintain close communication with the child's treating clinician.

Once the appropriateness of the parent and the clinician for this level of intervention have been established, the exploration of experiential contributors and past attachment experiences associated with problematic parenting interaction may be completed. Once again, it is pivotal to engage the parent's curiosity and desire to get to know the child. I usually invite parents to be my coinvestigators. I invite them to do "detective work" as we learn about the parent, the child, and about their implicit and explicit dynamics.

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