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MYTH-BUSTING EMDR THERAPY IN THE PERINATAL PERIOD:

A Call to Clarity for EMDR Clinicians

BY Mara Tesler Stein, Psy.D., PMH-C EMDRIA Approved Consultant and Trainer EMDR Europe Accredited Consultant

Let's talk about myths.

Because they're everywhere.

When clients walk into your office already pregnant… or find out they're pregnant while in treatment… or are deep in the postpartum fog… or five years into fertility treatments… or grieving a loss so profound there aren't words for it yet…the question comes up.

Can I use EMDR therapy with this person? If so, which phases? When? Is it safe? Is it appropriate? Will I do harm?

These are good questions.

These are ethical questions.

But far too often, they're answered with fear, not data. With assumptions and opinions passed down from consultant to consultee, often rooted not in clinical discernment but in omission bias, and in a well-meaning but misplaced idea of protection.

So, let's pause and ground ourselves in what we know about trauma, the brain, development, healing, and attachment. And about what's at stake when we *don't* intervene.

FIRST: WHAT IS THE PERINATAL PERIOD, REALLY?

The perinatal period encompasses more than just a medical category. It is a profoundly formative psychological and physiological window, encompassing fertility challenges, pregnancy, birth, postpartum, loss, and the early years of parenting (Isobel, 2023; Hopkins & Hellberg, 2021).

This period is often anticipated as a time of joy and bonding. And for many, it is. However, for others, it's a time of activation, grief, and reorganization. Past trauma comes roaring forward. New trauma unfolds in real time. There are layers of loss. The nervous system is in flux. Identity is shifting. Relationships are renegotiated. The stakes are high.

From a developmental lens, the perinatal period is as rich and complex as adolescence. It demands the integration of new roles, new responsibilities, and a new sense of self.

Parental identity begins to form here, and it does so amid enormous hormonal, psychological, and relational upheaval (Christian, 2012; Barrero-Castillero et al., 2019).

And let's be clear: Trauma during this period is not rare.

Whether it's the trauma of obstetric violence, the shock of a high-risk pregnancy, the heartbreak of a miscarriage, the terror of a neonatal intensive care unit (NICU) stay, or the quiet erosion of self and intimacy in the long shadows of infertility—these are not edge cases. They are part of the clinical landscape.

We need to stop asking if trauma healing is possible in the perinatal period. It is. Unequivocally.

The better question is: Are we ready to meet it with clarity, confidence, and care?

THE ROLE OF EMDR: NOT JUST TRAUMA RESOLUTION—IDENTITY INTEGRATION

When we use EMDR in the perinatal period, we are not just reducing symptoms. We are facilitating integration. We are supporting the development of a coherent parental identity—one that includes, but is not defined by, trauma (Stein & Miller, 2021; Stein et al., in press).

We are helping the nervous system organize around safety and connection rather than fear and fragmentation.

This involves not only pulling out the 'shrapnel' of trauma left in the nervous system but also supporting the development of emotional and relational 'connective tissue.'

> **This is prevention.**
>
> **This impacts attachment.**
>
> **This mobilizes intergenerational healing.**

The perinatal period is a time of immense plasticity—not just for the developing baby, but also for the parents. The brain is reorganizing. Hormones are shaping attachment systems. The opportunity for therapeutic impact is profound (Sanjuan et al., 2019;

Christian, 2012).

So yes let's bust the myths. Let's unpack the biases. Let's step into the full responsibility and privilege of working with clients during this exquisitely sensitive and developmentally potent time.

Let's trust the work, our clients, their nervous systems, and ourselves.

MYTH #1

You can't use EMDR during pregnancy or fertility treatment (and you should be very, very careful if you do).

REALITY: Pregnancy status in and of itself is not a contraindication for any phase of EMDR therapy. Not even "highrisk" pregnancy. Fertility treatment is not a contraindication either.

What is contraindicated is proceeding without a good working alliance, solid preparation, and a clear understanding of what's driving the client's distress.

Yes, of course, we assess readiness. Yes, of course, we tailor the pacing— this is consistent with EMDR best practices for all clients. However, we do not need to stop reprocessing just because someone is pregnant. We do not need to abandon trauma-focused work because they are doing in vitro fertilization (IVF). This period may be the perfect time to do it.

But let's be honest: so many of us hesitate here.

> **As clinicians, we're taught to be careful.**
>
> **We want to do no harm.**

But that ethic, when not accompanied by developmental wisdom and a careful assessment of risks and benefits, can pull us into a subtle but powerful cognitive error: omission bias (Atallah et al., 2022).

Omission bias is the belief that harm caused by an action is worse than harm caused by inaction. It's safer to do nothing than to risk doing the wrong thing.

And this shows up all the time in the perinatal period:

- "What if I reprocess something with the client and it causes stress for the baby?"
- "What if the client gets upset and goes into labor?"
- "What if it's better to wait? Just give it time."

These questions are so common that the reasons given as a general guideline to avoid or wait, have become clinical folklore. But here is what is often missing from that internal calculus:

The impact of untreated trauma is not neutral.

Avoiding EMDR across the board for pregnant clients doesn't protect them.

Instead, it can prolong suffering. It can fuel dysregulation. It can increase risk for both the parent and the developing baby (Grekin & O'Hara, 2014; Baas et al., 2020; Gelaye et al., 2020).

We know the data:

- Untreated PTSD during pregnancy is linked with preterm birth, low birth weight, and impaired attachment (Grigoriadis et al., 2018; Sanjuan et al., 2021).
- Postpartum trauma impairs bonding and increases the risk of relational disconnection, even years later (Doyle et al., 2023; Eitenmüller et al., 2022).
- Trauma in the perinatal period often goes unrecognized and untreated because we tell ourselves it's too risky to intervene (Arch et al., 2012).

> **"Omission bias is the belief that harm caused by an action is**

worse than harm caused by inaction. It's safer to do nothing than to risk doing the wrong thing.

However, let's be extremely clear: *Not* treating trauma is not the same as keeping someone safe. When reprocessing would be appropriate if the client weren't pregnant, just leaving the trauma where it is—unintegrated, intrusive, impacting pregnancy and fetus as well as the mother—has measurable consequences.

> **We can do better.**
>
> **And we must.**

Let's ground this in more data:

- four out of five women will become pregnant at some point in their lives (Sedgh et al., 2014).
- Between 15–21% of pregnant people meet criteria for PTSD (Yildiz et al., 2017; Khoramroudi, 2018).
- Many enter pregnancy with unresolved trauma, and pregnancy itself can reactivate it, both physiologically and emotionally (Isobel, 2023; Hopkins & Hellberg, 2021).

When PTSD, anxiety, or depression go untreated in this period, the risks are clear. We see higher rates of:

- Preterm birth (Sanjuan et al., 2021)
- Low birth weight (Gelaye et al., 2020)
- Preeclampsia (Grigoriadis et al., 2018)
- Poor bonding and impaired parent-infant attachment (Doyle et al., 2023)
- Intergenerational transmission of trauma (Chamberlain et al., 2019)

So, the question isn't, *"Should we treat trauma during pregnancy?"* The real question is, *"How can we afford not to?"* But what about stress and fetal development?

TOXIC STRESS AND THE DEVELOPING FETUS

Clinicians wary of using EMDR reprocessing during pregnancy cite fears about the adverse impact of stress on the developing fetus.

The problem with that argument is that the stress exposure they are worried about is already happening.

Untreated trauma and chronic dysregulation during pregnancy do not just affect the pregnant person—they shape fetal development. Toxic stress, defined as "excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering support by a stable and responsive relationship," has measurable adverse consequences for the developing fetus (Barrero-Castillero et al., 2019, p. e688) and contributes to poor obstetric and neonatal outcomes.

Toxic stress disrupts the developing architecture of the brain. It alters the fetal stress response system. It lowers the infant's threshold for reactivity and increases lifetime risk of stress-related illness (Shonkoff et al., 2009; Wei et al., 2023).

The cost of not treating trauma during pregnancy is not theoretical. It's embedded in the nervous system of the next generation.

ADAPTIVE STRESS: WHAT EMDR ACTUALLY DOES

According to the taxonomy of stress developed by the National Scientific Council on the Developing Child (NSCDC), adaptive stress occurs in the presence of attuned support and helps build resilience (Barrero- Castillero et al., 2019). EMDR therapy does not induce toxic stress—it more closely resembles adaptive stress.

Adaptive stress, when held in the context of attuned therapeutic support, is not harmful—it is developmental. According to the taxonomy of stress by the NSCDC, stress that occurs in a buffered, co-regulated environment helps build resilience (Barrero-Castillero et al., 2019). When we engage in EMDR reprocessing during pregnancy with care, containment, and connection, we're not overwhelming the nervous system—we're strengthening it. We're helping the parent-to-be metabolize what was too much, too soon, too fast—this time in a titrated, time-limited way. Doing so with appropriate containment, co-regulation, and movement towards resolution mobilizes integration.

EMDR DURING PREGNANCY: SAFETY AND EFFICACY

Multiple studies confirm that EMDR is not only safe but also effective during pregnancy:

- A systematic review by Baas et al. (2020) found clinically significant decreases in PTSD symptoms following EMDR with effects lasting up to 36 months.
- In a large, multicenter RCT, Baas et al. (2022) found EMDR reduced fear of childbirth, and those who received EMDR were seven times less likely to request labor induction (Baas et al., 2023).
- Arch et al. (2012) concluded that the hypothetical risks of trauma-focused treatment during pregnancy were vastly outweighed by the risks of inaction.

Avoidance does not equal protection. It can result in prolonged dysregulation for both the parent and the developing baby.

Clinician Takeaway: If your client is pregnant and experiencing trauma symptoms, trauma-focused treatment is not contraindicated. It's indicated. Proceed with attunement, with attention to EMDR best practices, and with full respect for the intensity of the perinatal period—but don't default to delay. That's not safety. That's **omission bias** in action.

MYTH #2

You should wait until hormones settle and the mom's body recovers before using EMDR in the postpartum period.

REALITY: Hormonal shifts do not preclude trauma work.

Yes, the postpartum period is biologically dynamic. There are sweeping hormonal fluctuations, interrupted sleep, physical recovery, and overwhelming new responsibilities. This is not a reason to avoid trauma work. This is precisely why timely intervention matters.

This is one of the highest-risk windows for the onset or exacerbation of mood and anxiety disorders. People are vulnerable, yes—but vulnerability is not the same as fragility. And trauma left untreated is not inert.

The postpartum period is often when trauma from the birth, or from earlier parts of the perinatal journey, shows up. It hides behind depressive symptoms. It hijacks bonding. It

undermines nursing. It erodes the foundation of the parent-infant relationship (Grekin & O'Hara, 2014; Eitenmüller et al., 2022).

TRAUMA DOESN'T WAIT—AND NEITHER SHOULD WE

Clients often arrive in the postpartum period with multiple stressors layered on top of each other:

- A traumatic birth or NICU stay
- A prior traumatic birth
- Medical complications for the parent and/or baby
- Feeding challenges, sleep deprivation, or unexpected loss
- Isolation, identity shifts, and a profound sense of overwhelm

These clients don't need to be told to "give it time." They need relief. They need integration. And they need someone who sees the urgency without pathologizing the moment.

What EMDR offers is not destabilization. It's regulation. When applied skillfully with attunement to readiness and pacing, EMDR can be a powerful stabilizing force. It helps move trauma memories out of the intrusive present and into the past, where they belong.

Here's what the data tells us:

- PTSD and depression are comorbid in up to 35% of postpartum cases (Staudt et al., 2023).
- PTSD is often misdiagnosed or underdiagnosed because it hides behind depression and anxiety (Grekin & O'Hara, 2014).
- Untreated PTSD can impair bonding, disrupt breastfeeding, and destabilize relationships (Doyle et al., 2023).

And here is what the clinical research tells us:

- Choriano et al. (2019) found that postpartum EMDR significantly reduced PTSD symptoms and depressive symptoms while improving mother-infant bonding and psychological well-being. And that a single EMDR session shortly after a traumatic birth led to lasting symptom relief.

- Wetherell (2022) found that even three sessions resulted in clinically significant reduction in trauma symptoms.

NEUROBIOLOGY, HORMONES, AND THE WINDOW FOR INTERVENTION

From a neurobiological perspective, the postpartum period is a window of heightened plasticity. The brain is reorganizing. The parent-child bond is forming. Hormones like oxytocin, prolactin, and cortisol are actively shaping attachment and stress response systems (Sanjuan et al., 2019; Christian, 2012).

This is not a time to avoid trauma work—it's a time to do it with skill, support, and care. The work of processing traumatic material during this window can shift not just symptoms but developmental trajectories for both parent and child.

Avoiding EMDR reprocessing when a client is otherwise adequately prepared doesn't allow someone to "adjust to motherhood." It leaves her stuck in a loop of reexperiencing, hypervigilance, shutdown, and selfblame. These clients don't need time. They need treatment that is attuned, evidence-based, and timely.

Clinician Takeaway: Trauma in the postpartum period does not resolve on its own. The nervous system doesn't "wait for hormones to settle." It adapts—often maladaptively—unless we intervene. EMDR offers a compassionate, attuned pathway to resolution.

> **EMDR clinicians trained in the AIP model are already equipped to navigate complexity. When we apply that model thoughtfully—attending to the specific context, identity shifts, attachment processes, and somatic experience of perinatal clients—we support profound change.**

MYTH #3

You shouldn't use EMDR for perinatal grief or bereavement.

REALITY: Grief and trauma are often inextricably linked, especially with perinatal

losses, and EMDR is uniquely positioned to address both.

Whether it's miscarriage, stillbirth, neonatal death, SIDS, termination for medical reasons, or the collapse of a long-hoped-for fertility journey, perinatal grief is often traumatic. And yet, it remains one of the most disenfranchised forms of grief. Clients are not only mourning the loss of a longed-for future, and a fundamental violation of normative expectations, but they may also be doing so in isolation with little social acknowledgment and minimal support.

Therapists often hesitate to intervene:

- "What if it's too soon?"
- "What if it's too painful?"
- "Isn't suffering necessary to heal?"

But when trauma is blocking grieving, time does not heal—it hardens. What clients need is not to wait longer but to process what is keeping them stuck. That is where EMDR comes in.

EMDR helps clear the pathogenically linked trauma components— the flashbacks, the guilt, the shame, the bodily memories, the silence from the heart rate doppler, the expression on the nurse's face. It allows grief to move. It allows mourning to take its rightful place.

What the literature says:

- PTSD rates after perinatal loss range from 17% to 67% depending on the type and timing of the loss (Christiansen et al., 2013; Farren et al., 2020).
- EMDR has been found effective in treating grief-related trauma, including following perinatal losses (Meysner et al., 2016; Solomon & Rando, 2012).
- Sprang (2001) demonstrated that EMDR supports complicated mourning by helping integrate traumatic aspects of the loss.

Importantly, EMDR is not about "letting go" of the loss—it's about letting go of the trauma that keeps grief from unfolding. As Solomon and Rando (2007) put it, "When trauma

blocks grief, it must be reprocessed before mourning can proceed."

The clinical reality? In practice, we see this all the time:

- The clients who can't stop replaying the silence in the delivery room.
- The ones who avoid baby showers and grocery stores for months or even years.
- The ones who try not to cry because if they start, they are afraid they will never stop.

We honor grief when we help metabolize the trauma. We honor the love that remains by helping make space for it.

Clinician Takeaway: When clients are trapped in traumatic grief, EMDR is not just appropriate—it is a lifeline. We are not erasing what happened. We are helping the nervous system stop reliving it so that mourning can unfold with dignity, humanity, and presence.

MYTH #4

You need special EMDR protocols for perinatal work.

REALITY: You do not need specialized protocols. You need robust case conceptualization, strong attunement, and a deep understanding of the perinatal context.

There is a persistent belief that trauma in the perinatal period is so unique that each type of event requires a special protocol. But the reality is, the Standard EMDR Protocol works beautifully. What clinicians need is not a set of specific scripts, but a refined lens. One that considers the normative developmental tasks of the perinatal period and the ways trauma can interfere.

EMDR clinicians trained in the AIP model are already equipped to navigate complexity. When we apply that model thoughtfully—attending to the specific context, identity shifts, attachment processes, and somatic experience of perinatal clients—we support profound change.

What You Do Need:

- Clear understanding of what you are treating
- Developmentally informed case conceptualization
- Attuned assessment of readiness before moving to reprocessing phases
- Flexible pacing and titration
- Tracking of the client's window of tolerance

You do not need to rewrite the protocol. You need to anchor it in the Integrated Conceptual Lens—which weaves the three developmental tasks of the perinatal period (developing parental identity, managing emotions, and managing relationships) with EMDR's core trauma themes (safety, choice, responsibility, and belonging) (Stein & Miller,

2021, Stein, et al, in press).

What the research supports:

- The standard protocol has been shown effective for trauma in the perinatal period across a variety of presentations (Baas et al., 2020; Chiorino et al., 2019).
- Target selection, preparation, and pacing are more predictive of success than the use of an alternate protocol.
- When used appropriately, EMDR supports both symptom reduction and improved parent-infant bonding (Doyle et al., 2023).

As with all trauma work, good clinical thinking matters. Clinicians need to consider the impact of prior trauma, current medical stressors, unresolved grief, anticipatory anxiety, and systemic barriers to care. But this does not require a new tool. It requires skilled use of the one you already have.

Clinician Takeaway: The Standard EMDR Protocol is virtually always sufficient when used with fidelity, nuance, and understanding of the perinatal context. Your clients do not need a special protocol. They need you: present, attuned, informed, and willing to trust the process.

MYTH #5:

The SUDs can't get to zero because the baby died.

This is one of the most persistent and profoundly misunderstood myths we encounter in perinatal EMDR work. The belief that a Subjective Units of Distress (SUD) level cannot reach zero, or even should not reach zero, because the outcome of the trauma involved the death of a baby is rooted in a fundamental misunderstanding of what a SUD rating measures—and what it does not. Instead, it posits that it's "ecologically valid" for the SUD to remain at 1 or 2, or even 3, because, after all, a baby died.

Let's be very clear: Getting a SUD to zero does not mean that the loss is erased. It does not mean that clients no longer love or miss their babies. It does not mean that the death no longer matters or that the memory has somehow been "sanitized" of meaning. Quite the opposite. A SUD of zero reflects that the memory can now be accessed without the

client experiencing current *disturbance.* The nervous system has updated its appraisal of the event: *This happened. It was real. It was awful. And it's over. I survived it. It's not happening now*.

In perinatal work, we are often carrying immense emotional weight alongside our clients, and the idea that reducing the SUD to zero might be disrespectful to the magnitude of their loss is a deeply compassionate but ultimately misguided concern. The goal of EMDR is not to diminish the significance of the loss, but to metabolize the trauma around it so that the client is no longer trapped in a loop of unprocessed suffering. EMDR therapy facilitates adaptive information processing, even in the context of reproductive loss, and traumatic memories associated with perinatal experiences can be reprocessed to resolution, including when the outcome is death.

We must remember that grief and trauma are not the same. EMDR is not intended to eliminate grief, nor should it. But trauma, when left unprocessed, interferes with a person's capacity to grieve at all. When the nervous system is stuck in survival mode—flooded, fragmented, or numbed out—it cannot engage in the organic and necessary process of mourning. It is because the baby died that we must reprocess until the SUD is zero. Not despite it.

Trauma reprocessing does not erase love. It allows room for it. It makes space for integration. It gives clients their lives back—not without sadness, but without that sadness being hijacked by terror, helplessness, or shame.

So yes, the baby died. And yes, the SUD can get to zero.

MYTH #6:

You must use a recent event protocol following a perinatal trauma.

This is a well-meaning misunderstanding, but one that can limit our clinical effectiveness and deny clients access to deeper healing.

When a client presents following a recent perinatal trauma—whether miscarriage, stillbirth, birth trauma, or a NICU stay—it may feel intuitive to reach for a recent event protocol. The trauma is fresh, the symptoms acute, and we want to help. But this reflex can reflect an underlying myth: that the recency of the trauma dictates the best entry

point for EMDR therapy.

While early intervention protocols, such as the Recent Traumatic Episode Protocol (R-TEP), have their place—especially when the client is narrating in the present tense or there is no "worst part" because the episode itself is the target (personal communication, Elan Shapiro, 2023)—there is no research supporting the idea that recent event protocols are inherently *superior* to the standard EMDR protocol in the immediate aftermath of trauma, perinatal or otherwise. The standard EMDR protocol remains the most researched and validated approach in the EMDR literature (Maxfield & Hyer, 2002; Shapiro, 2018).

The standard protocol was developed based on the Adaptive Information Processing (AIP) model, which recognizes that present-day symptoms are often linked to unprocessed, pathogenic memory networks—networks that may or may not be directly related to the recent trauma (Shapiro, 2001). By using the standard protocol, the clinician stays out of the way, allowing the associative networks to do what they know how to do when given the opportunity. The flexibility of EMDR therapy lies not in abandoning the standard protocol, but in applying it with attunement and clinical discernment.

There are, however, times when a recent event protocol can be helpful, not necessarily based on when the trauma occurred, but because the nervous system remains overwhelmed or the crisis is still unfolding. In these cases, we aim to reprocess with containment rather than to mobilize the nervous system to pick up all the points of disturbance through the associative networks using the standard protocol. Here, the goal is stabilization through turning down the heat on the traumatic episode, not full integration. This is particularly relevant when the trauma is ongoing, the memory is not yet organized enough in the nervous system to identify a 'worst part,' or the client's internal resources are taxed beyond capacity.

Used skillfully, a recent event protocol can allow us to address acute traumatic material in a titrated, developmentally attuned way. It can support stabilization when full reprocessing would exceed the client's window of tolerance. And it can build trust in the work itself, offering relief, not re-traumatization. But again, this is not about timing, per se. It is about the state of the memory in the nervous system and the demands of the present moment.

As always, formulation trumps formula.

MYTH #7:

Float-backs are disrespectful after perinatal trauma.

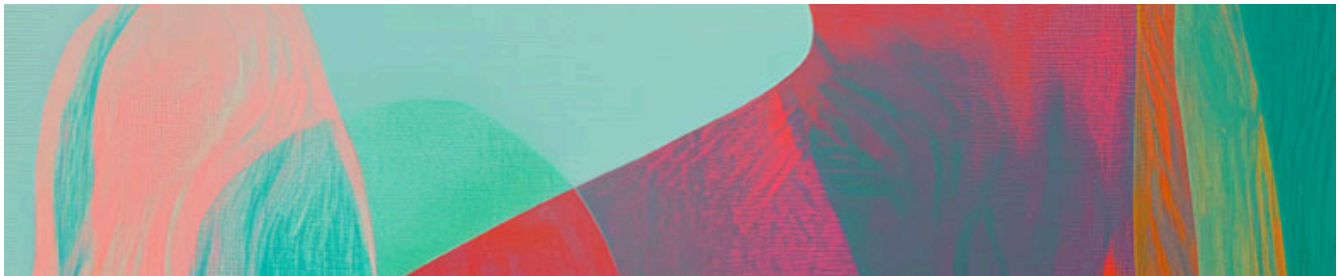
This myth often arises alongside the overemphasis on recent event protocols: the idea that inviting a client to float back from a perinatal trauma is somehow disrespectful or unnecessary. But this assumption is not grounded in the AIP model, and it can severely limit our clinical scope.

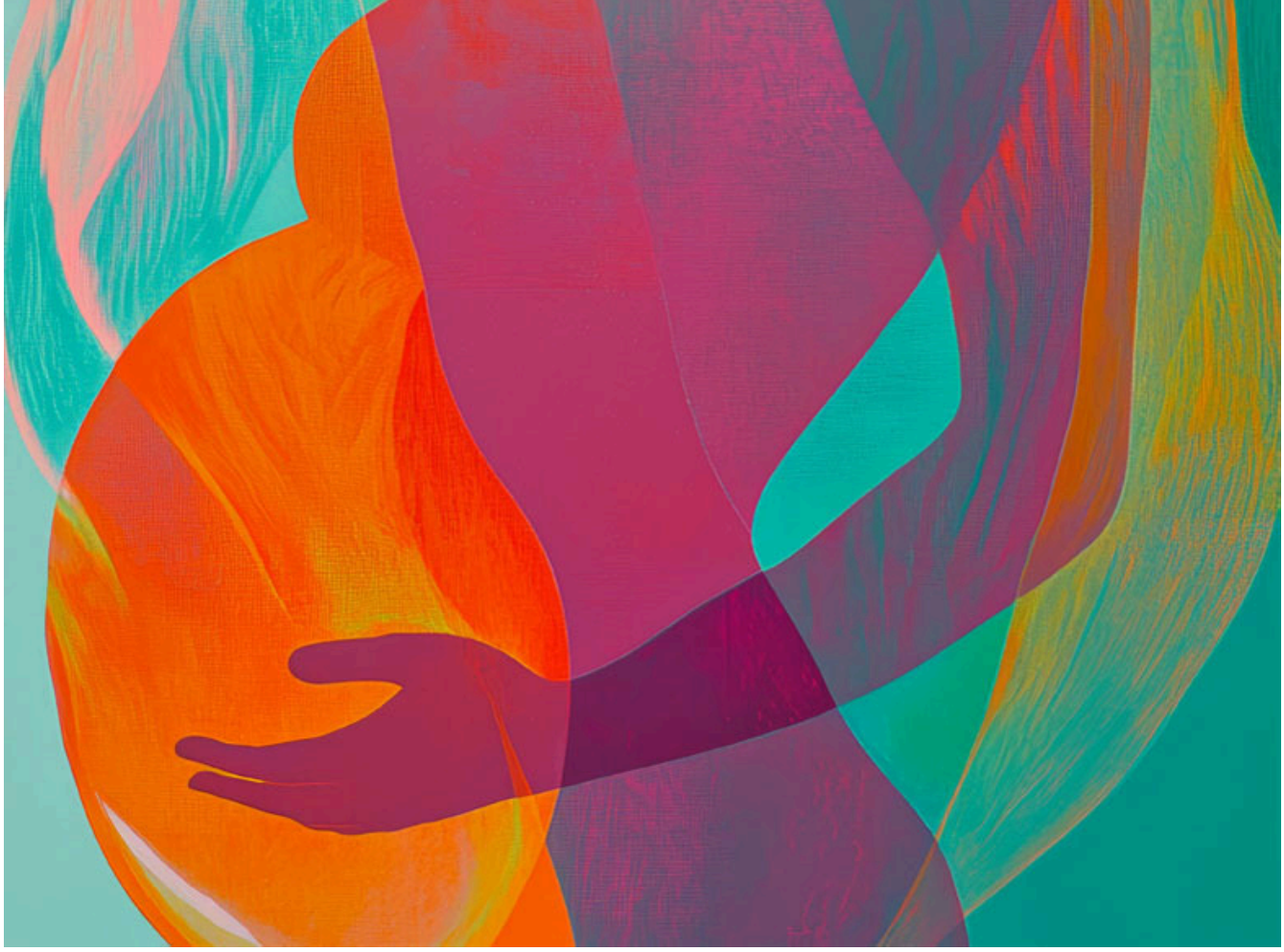
The perinatal period is not just a time-bound chapter in a client's life. It is a developmental period—a profound window of attachment reorganization, identity transformation, and multigenerational meaning-making. A perinatal trauma rarely occurs in isolation. It often stirs up latent or unresolved material: earlier attachment injuries, relational wounds, messages about self-worth, safety, competence, or grief long buried.

Float-backs are one of our key tools to access these deeper roots. When we follow the disturbance and invite the nervous system to show us where it's encountered this before, we are doing exactly what EMDR therapy was designed to do. This is not a detour—it is the work.

Avoiding float-backs leads us to privilege recency over relevance, working only at the surface of our clients' experience. But trauma integration in the perinatal period is not about symptom relief alone; it's about mobilizing developmental transformation and healing. And transformation requires trust: in the model, in the protocol, in the clients' nervous systems, and in their capacity to tolerate and resolve what arises when we follow the thread.

Ultimately, the decision about where to begin must be collaborative between the client and therapist. Explaining the reasons why we might recommend starting with an earlier memory allows the client to have the context to participate in the decision. And, of course, there will be times when beginning with the most recent trauma memory is the most clinically appropriate choice.





As EMDR therapists, our task is not to shield clients from the past but to help them meet it with support and integration. The AIP model gives us the roadmap. The standard protocol gives us the tools. Let's not abandon them out of fear—or myth.

MYTH #8:

Men aren't impacted by the perinatal experience, so EMDR isn't necessary.

REALITY: Men absolutely experience trauma related to fertility, pregnancy, loss, birth, and the postpartum period—and they often do so in silence.

Cultural norms around masculinity, emotional suppression, and caregiving roles often leave fathers, non-birthing partners, and intended parents out of the perinatal mental health conversation. Men and other non-gestational parents may say, "It didn't happen to me. It didn't happen in my body." They step back, perhaps imagining that this is how to best support their birthing partner, who perhaps did experience trauma in the body.

The result?

Their trauma goes unrecognized, their losses unacknowledged, and their suffering untreated.

Men may present with externalizing behaviors, substance use, or workaholism. They may be irritable, shut down, or emotionally distant. These symptoms are often missed or misattributed, and clinicians may not ask the deeper questions about fertility trauma, birth experiences, NICU stays, or the impact of pregnancy loss.

Here is what the research tells us:

- One in ten new fathers experiences postpartum depression (Paulson & Bazemore, 2010).
- Men who have experienced pregnancy loss report PTSD symptoms, including nightmares, intrusive images, hyperarousal, and persistent avoidance (Due et al., 2017).
- Fathers with children in the NICU are at risk for traumarelated symptoms long after discharge, particularly when they felt helpless during the medical crisis (Hendriks et al., 2019).

EMDR therapy is no less relevant for men. Their trauma is no less real. Their identities as fathers are no less shaped by the perinatal period.

When we exclude men from perinatal trauma work—whether explicitly or implicitly—we uphold the same myths that keep trauma hidden: That strength means silence. That grief has a lesser place for non-gestational parents. That trauma and loss in caregiving don't create attachment wounds.

When we invite men into trauma reprocessing, we affirm their experiences. We help them metabolize what they have carried. We interrupt intergenerational patterns that tell them they must go it alone.

Clinician Takeaway: If your male client or non-gestational parent is presenting with distress linked to a fertility journey, pregnancy, loss, birth, or the transition to parenthood, EMDR is not only appropriate— it's essential. Trauma doesn't discriminate by gender or gestation. And neither should we.

FINAL THOUGHTS: EMDR IS PREVENTION

Using EMDR therapy during the perinatal period isn't just about symptom reduction. It is about interrupting cycles of trauma that reverberate through bodies, families, and generations. This is about meeting clients during one of the most biologically and emotionally sensitive periods of life—and offering real healing.

By using EMDR during the perinatal period:

- We disrupt intergenerational transmission of trauma (Chamberlain et al., 2019)
- We foster secure attachment and co-regulation (Doyle et al., 2023)
- We reduce symptom load, improve maternal-infant bonding, and expand emotional capacity (Baas et al., 2020)

When we skillfully apply EMDR through the lens of the perinatal period—respecting its developmental significance, physiological intensity, and profound psychological transitions—we're not only reducing symptoms. We're supporting transformation.

So, let's not let myths or fear hold us back. Let's treat what's treatable. Let's trust the work.

And let's do it with precision, presence, and the deepest respect for what our clients carry.

We are helping parents be more present with themselves and their children.

We are doing prevention work, one nervous system at a time.

Mara Tesler Stein, Psy.D., PMH-C is a clinical psychologist and EMDR consultant and trainer in Chicago and Israel. She is the founder and director of The Touchstone Institute for Perinatal Training where she offers both foundational and advanced EMDR trainings, which take deep dives into the intersections and applications of EMDR and perinatal mental health.
Dr. Stein is a staunch advocate for trauma-focused care and is trained and certified in a range of integrative trauma therapies. Dr. Stein is also certified in emotion-focused family and couples therapy, brainspotting, is a Gottman Certified Therapist, and continues to deepen her training in clinical hypnosis, yoga-informed treatment,

advanced applications of EMDR, and ego-state therapies.
She is the editor of the forthcoming book, EMDR for Perinatal and Infant Mental Health, co-author (with Deborah Davis, Ph.D.) of Parenting Your Premature Baby and Child: The Emotional Journey (Fulcrum, 2004) and Intensive Parenting: Surviving the Journey Through the NICU (Fulcrum, 2013). She has also collaborated on book chapters in the areas of perinatal loss, EMDR treatment, and trauma-focused psychological care for NICU families.
Her trauma work is grounded in her personal perinatal journey, which began in 1995, taking her through infertility, twin pregnancy, prolonged hospital bedrest, the NICU, and years of raising NICU graduates.
*You can find her and her workshops at **www.touchstoneinstitute.org** and at **mara@touchstoneinstitute.org**.*

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