Emotional Wound or Traumatic Injury Practice

Workshop Handout — EMDRIA Conference, Anaheim 2026

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Introduction

Emotional wound: The system can still regulate and function. The disruption is organizational: fixed meaning, rigid scripts, narrowed anticipation. The person can still access their emotional processes, maintain relationships, and function in daily life, even if doing so is costly or constrained. The wound shapes how experience is organized but does not compromise the system's basic functional capacity.

Traumatic injury: The system's functioning is compromised. Regulation fails or is severely limited. Integration cannot occur. The person cannot move through the phases of the emotional architecture without flooding, shutdown, or fragmentation. The disruption exceeds organizational rigidity and touches the system's basic capacity to process experience.

What This Exercise Is About

Not all emotional pain produces the same kind of disruption. An emotional wound shapes how the system organizes experience: what things mean, what is expected, what the person is instructed to do. A traumatic injury disrupts how the system

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functions: its capacity to regulate, integrate, and remain open to new information is compromised at a more fundamental level.

The distinction matters clinically because it determines what the work needs to do. Organizational disruption requires deconstruction and reconstruction of meaning, value, and script. Functional disruption requires restoration of the system's basic capacity to process experience before organizational work can begin.

This exercise will help you apply that distinction to clinical presentations.

Instructions

Read each vignette carefully. For each one, decide:

☐ **Emotional wound:** The system is functioning but organized around a fixed and costly meaning.

☐ **Traumatic injury:** The system's basic functional capacity has been disrupted.

☐ **Uncertain:** The presentation could be either, depending on information not yet available.

If you mark uncertain, note which conversion factors you would want to assess: intensity beyond the window of tolerance, isolation during the experience, repetition before recovery, developmental timing, identity threat, or absence of repair.

There are no trick questions. Some scenarios are deliberately ambiguous. The uncertainty is the clinical information.

Vignette 1: Maria

Maria is a 38-year-old attorney who describes herself as someone who has never been able to trust her own judgment. She traces this to a period in her early career when a senior partner consistently dismissed her contributions in front of colleagues, took credit for her work, and told her privately that she lacked the instincts for the job. She eventually left the firm. She is high-functioning, maintains close relationships, and has built a successful independent practice. But she hesitates before every significant professional decision, second-guesses herself after every client interaction, and frequently defers to others in situations where her own judgment is clearly sound. She has never sought therapy before and describes her difficulty as "just how I am."

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☐ Emotional wound ☐ Traumatic injury ☐ Uncertain

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Vignette 2: David

David is a 45-year-old teacher referred by his physician after a series of unexplained physical symptoms including chronic fatigue, gastrointestinal problems, and recurring headaches that have no medical explanation. He describes his childhood as "fine" and is reluctant to connect his physical symptoms to his emotional life. When pressed he mentions that his father was "strict" and that he learned early not to show weakness or need. He is well liked by colleagues, described by his physician as calm and composed, and insists that nothing particularly difficult has happened to him. In session he speaks fluently about his life but becomes visibly uncomfortable when asked about his emotional experience and changes the subject. He has no memory of feeling genuinely close to either parent.

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Vignette 3: Sofia

Sofia is a 49-year-old psychologist with over twenty years of clinical experience. She was involved in a serious car accident at age 2 in which her mother died. She has no conscious memory of the accident but believes she cannot fly because the sensation of takeoff feels similar to what she imagines the braking of the car must have felt like. She recently flew to the United States for the first time. The takeoff was upsetting, but she completed the flight.

Sofia lost her father a few years ago, at age 68, following the earlier deaths of two uncles. She describes feeling as though everyone close to her will soon die, but she does not organize her distress primarily around loss or abandonment. What is more striking is the way she relates her own experience to her father's: in conversation she consistently routes her own responses through his. Facing any experience and she will speak immediately about the experiences he had, the things he loved, the moments they shared. Her own reaction to the events is rarely where she lands. His is where experience becomes meaningful.

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She describes disliking people and preferring animals, yet she is genuinely warm and widely regarded as exceptionally friendly by colleagues and clients alike. She is married, has no children, and her professional functioning is excellent even when her health is not.

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Vignette 4: James

James is a 52-year-old man who sought therapy after his second divorce. He describes a pattern he recognizes clearly: he pursues relationships with intensity, becomes deeply attached very quickly, and then finds reasons to end them before the other person can leave him. He is articulate about the pattern, can trace it to his mother's emotional unavailability during his childhood, and has done significant therapeutic work over the years including two previous courses of therapy. He maintains stable employment, has close friendships, and describes himself as generally happy. The pattern activates specifically in romantic relationships and has not changed despite his insight and his genuine desire for a different outcome.

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Step 5: Elena

Elena is a 34-year-old nurse who grew up in a household where her mother had severe untreated depression. From an early age Elena took responsibility for managing her mother's emotional states, monitoring her moods, and suppressing her own needs to avoid adding to her mother's burden. She describes feeling chronically guilty when she prioritizes herself, difficulty knowing what she actually wants or needs, and a pervasive sense that her value to others depends entirely on what she can do for them. She is highly functional, professionally accomplished, and described by everyone who knows her as extraordinarily caring. She came to therapy because she realized she has never felt genuinely entitled to her own emotional experience.

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Vignette 6: Marcus

Marcus is a 41-year-old man who was referred to therapy following a breakdown at work. He describes a childhood marked by severe and unpredictable physical abuse from his father, which continued until he left home at sixteen. He has significant gaps in his memory of his childhood. In session he alternates between periods of detailed and apparently calm recounting of his history and sudden episodes of dissociation in which he loses track of where he is and what he was saying. He has difficulty regulating his emotional responses: minor frustrations produce intense anger that frightens him, and he sometimes goes days feeling emotionally numb and disconnected from his own experience. He has had multiple relationships that ended after episodes of dysregulation he could not explain or control.

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Vignette 7: Priya

Priya is a 27-year-old woman who sought therapy after ending a three-year relationship. She describes the relationship as loving but ultimately incompatible: her partner wanted children and she did not. The ending was mutual and relatively undramatic. She grieves the relationship genuinely and finds herself thinking about her former partner frequently. She feels sad, sometimes lonely, and uncertain about her future. She is not sleeping or eating normally, but has maintained her friendships. She believes it'll be very difficult to find a compatible partner because she's difficult. She wants support in moving through it because she "knows" this situation broke her inside.

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Vignette 8: Thomas

Thomas is a 48-year-old executive who describes a pervasive sense of fraudulence that has accompanied him throughout a highly successful career. Despite objective evidence of his competence and numerous professional achievements, he experiences intense anxiety before every significant presentation, meeting, or evaluation, convinced that he is about to be exposed as less capable than people believe. He traces this to a father who consistently raised the bar after each achievement, making approval always conditional on the next performance. He is highly regulated, intellectually sophisticated, and has never had a significant functional breakdown. The pattern is ego-dystonic: he knows the fraudulence narrative is not accurate but cannot feel that it is not.

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Vignette 9: Daniel

Daniel is a 38-year-old teacher who grew up with a father who was emotionally cold, critical, and unpredictable. He describes a childhood organized around managing his father's moods, never knowing which version of him would arrive home, and learning early that his own needs and feelings were an inconvenience. He spent most of his twenties in relationships that repeated the pattern: partners who were unreliable, withholding, or critical, which felt familiar enough to feel like love.

Seven years ago he met his current partner, with whom he describes a relationship he still finds slightly surprising in its steadiness and genuine warmth. He has never been in therapy before. He presents now because he has been having occasional nightmares in which his father appears, and because certain memories of his childhood sometimes surface during quiet moments and leave him feeling briefly unsettled. He is worried that something is wrong with him, that the past is catching up with him, and that he is not as healed as he thought he was.

In session he speaks about his childhood with clarity and without dissociation. He describes his current relationship as genuinely different from anything he experienced growing up, and wonders quietly whether he deserves his partner's consistent presence. He has not repeated his earlier relational patterns in this relationship. He is professionally stable, socially connected, and describes his daily life as genuinely good.

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Discussion

For each vignette, think:

What in the presentation told you what it was?

What information is missing that would change your assessment?

What does your assessment tell you about where the clinical work needs to begin?

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Answer Guide

Vignette 1 (Maria): Emotional wound. High functioning, organizational disruption around professional self-worth, fixed meaning about her own judgment. No functional compromise. Classic wound presentation: the system is running well but organized around a costly meaning built under specific relational conditions.

Vignette 2 (David): Uncertain, leaning toward wound with possible functional components. The somatic symptoms and emotional unavailability suggest the system may have developed around suppression so early and so completely that functional capacity was shaped rather than disrupted. Worth assessing developmental timing and whether genuine emotional processing is available at all.

Vignette 3 (Sofia): Uncertain, and deliberately so. Sofia is highly functional professionally and interpersonally, which argues for organizational disruption rather than functional compromise. However the trauma occurred at age 2, during the precise developmental window when identity and meaning-making capacity are being constructed through attachment. The loss of the primary attachment figure at that stage may not have disrupted a functioning system so much as shaped how the system developed, producing an identity organized around the surviving parent rather than around an autonomous self. The somatic dimension, the body carrying an implicit memory of an event the mind cannot consciously access, adds a functional layer that is present even in the absence of obvious dysregulation. Participants should be encouraged to identify what additional information they would need: the presence or absence of genuine self-referential meaning-making, the quality of her grief since her father's death, and whether her excellent functioning has always been present or represents a compensation for something less visible underneath.

Vignette 4 (James): Emotional wound. Highly functional, pattern-specific rather than pervasive, ego-syntonic enough to have been examined without destabilization. The persistence despite insight is a wound characteristic: the architecture is consolidated at the level of meaning and script, not at the level of functional disruption. SER is indicated.

Vignette 5 (Elena): Emotional wound, developmentally organized. High functioning, relational pattern specific, no functional disruption. The wound was built so early and so consistently that it presents as identity rather than as injury. Worth assessing whether the suppression of her own emotional experience has prevented genuine access to her emotional system, which would affect pacing.

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Vignette 6 (Marcus): Traumatic injury. Dissociation, memory gaps, affect dysregulation across contexts, alternating flooding and numbing, identity disruption, relational dysfunction across multiple relationships. Functional disruption is pervasive and multi-domain. Preparation and functional restoration precede organizational work.

Vignette 7 (Priya): Uncertain, leaning toward emotional wound rather than normal grief, with an important third possibility worth exploring. The sleep and eating disruption, the belief that she is difficult and will struggle to find compatible partnership, and the conviction that this situation broke her inside suggest the relationship ending has activated or confirmed a pre-existing organizational pattern rather than simply producing acute grief. However at 27 Priya has grown up in a cultural environment saturated with trauma language as the primary framework for emotional difficulty. The conviction that she is broken inside may reflect genuine organizational disruption, or it may reflect the meaning the culture has taught her to assign to this kind of pain. Distinguishing between an actual wound, a normal grief response, and the internalization of a cultural trauma narrative is one of the most important and most underaddressed clinical skills in contemporary practice. The assessment question is not only what is happening in the architecture but where the meaning being constructed about what is happening actually came from.

Vignette 8 (Thomas): Emotional wound. Highly functional, pattern-specific, ego-dystonic, cognitively accessible. The conditional approval architecture is consolidated at Phase 4 and 5: value assignment and meaning. Classic SER candidate: the architecture is clear, the functioning is intact, and the person has sufficient reflective capacity and motivation to do the work.

Vignette 9 (Daniel): Neither wound nor traumatic injury. This is a healed wound: a genuine scar. The original architecture was real and costly: an identity organized around managing an unpredictable attachment figure, a relational pattern that repeated itself across his twenties, a system that had learned to expect emotional unavailability as the condition of closeness. But seven years of consistent, warm, genuinely different relational experience have done what good relationship does when the system is ready to receive it: produced repeated positive prediction errors that gradually revised the architecture from the inside. The nightmares and occasional unsettling memories are not signs of ongoing injury. They are signs of integration: the system is completing its processing of experiences that are no longer being actively defended against. The one remaining tender spot is the quiet question of whether he deserves his partner's presence. That is the scar's last visible mark: the old identity conclusion about his own worth has not fully dissolved even though the architecture around it has reorganized. It does not require deconstruction. It requires the kind of witnessing that good therapy and good relationship both provide: someone who receives the question without answering it

for him, and whose consistent presence gradually makes the question feel less urgent and less true. The most important clinical move here is not to begin deconstructing an architecture that has already reorganized itself, but to help Daniel recognize what his symptoms actually mean: not that the past is catching up with him, but that it is finally letting go.

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