Praise for the First Edition:

“Clear and engaging, peppered with relevant case histories, this book would make an important addition to anyone’s EMDR-related book collection.”
—Dr. Robin Logie, EMDR UK and Ireland

—Carol Forgash, LCSW, BCD

“This book is a jewel for EMDR clinicians. It is also recommended for any professional interested in the treatment of complex disorders.”
—Dolores Mosquera, MS, Amazon Review

This innovative resource for therapists trained in standard EMDR delivers a powerful set of EMDR-based “Tools”—useful strategies for helping difficult-to-treat clients with complex emotional problems. The second edition reflects the author’s ongoing efforts to design treatments that can significantly extend the therapeutic power of methods based on an Adaptive Information Processing (AIP) model. It describes new discoveries that promote effective ways of structuring therapy sessions and refines original treatment procedures that can facilitate and safely accelerate therapeutic progress.

The book provides an overview of the principal issues in treating these complex emotional problems and describes highly effective methodologies with a wide variety of clinical presentations that originate in or include disturbing traumatic memories. It also describes how to integrate specific EMDR-related interventions with other psychotherapeutic treatments. Each intervention is examined in detail with accompanying transcripts, client drawings, and case studies illustrating the nuances and variations in intervention application. Bolstered by supporting theory and current research, the book also discusses how the concepts and vocabulary of other models of dissociation translate directly into EMDR’s AIP language.

NEW TO THE SECOND EDITION:

• Describes new strategies and refinements of standard methods for treatment of clients with complex emotional problems
• Includes two completely new chapters, “Internal Healing Dialogue” and “Case Example: Treating the Problem of ‘Attachment to the Perpetrator’”
• Provides new case examples on childhood sexual abuse
• Offers new sections on treating chronic defensive shame, the importance of “fast” vs. “slow” thinking processes, and new applications of “Loving Eyes” procedures
• Includes ebook with the purchase of print version

KEY FEATURES:

• Written by an EMDRIA-designated “Master Clinician”
• Delivers successful treatment alternatives for difficult-to-treat clients
• Provides a theoretical framework to guide assessment and treatment of clients with complex PTSD
• Includes specific AIP tools, verbatim therapy scripts, client drawings, and case studies
EMDR Toolbox
Jim Knipe, PhD, has been a licensed psychologist in private practice in Colorado since 1976 and has been using eye movement desensitization and reprocessing (EMDR) since 1992. He is a Trainer with Trauma Recovery/EMDR Humanitarian Assistance Program, an Eye Movement Desensitization and Reprocessing International Association (EMDRIA)-approved consultant and instructor, and was designated a “Master Clinician” by EMDRIA in 2007. He was a keynote speaker at the 2010 EMDRIA conference; 2015 EMDR Canada conference; and was an invited guest speaker at the 2006, 2007, 2010, 2014, and 2015 EMDRIA Annual Conferences; the 2006, 2008, and 2012 EMDR Europe Annual Conferences; the 2010 EMDR Asia Conference; and national EMDR conferences in Australia, Denmark, Germany, Scotland, Italy, Belgium, Sweden, Spain, the Netherlands, Turkey, Brazil, and Japan. He has been involved with Trauma Recovery/EMDR Humanitarian Assistance Programs (HAPs), serving as coordinator for training programs in Turkey and Palestine, and serving on the board of directors and as research and training director. He has also been involved in HAP in Oklahoma City, New York (following 9/11), Sri Lanka, and Indonesia. In addition, he is a coauthor of published outcome research documenting the effects of EMDR with survivors of 9/11 and with those traumatized by the 1999 Marmara earthquake in Turkey. Dr. Knipe has contributed chapters to EMDR Casebook (Manfield, 2002), EMDR Solutions, Volumes I and II (R. Shapiro, 2005, 2009), Healing the Heart of Trauma and Dissociation (2007), EMDR Scripted Protocols: Special Populations (Luber, 2009), and EMDR and Dissociation: The Progressive Approach (Gonzalez & Mosquera, 2012). He is a coauthor (with Dolores Mosquera) of articles describing EMDR-related methods of narcissistic self-idealization, and idealization of a partner in an abusive relationship.
To Nancy, who has given me the gift of love, friendship, and life partnership, and whose unequivocal support, encouragement, and unfailing patience were essential in the writing of this book.
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*Share EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation, Second Edition*

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Preface

In 1974, Hiroo Onoda, a Japanese soldier, came out of the jungle in the Philippines and was surprised to learn that World War II, which actually ended in 1945, was now over. This man had been caught in a time warp, stuck in a “reality” that no longer existed, with intense but unfortunate loyalties to people and institutions long gone. His situation resembled that of many adult psychotherapy clients suffering from complex posttraumatic stress disorder (Complex PTSD) and dissociative personality structure. For many of these individuals, who come to us with hope and even some degree of trust that we will help them, the war is not yet over. They are attempting to live life in a way that other people deem to be “appropriate” and “normal,” while also frequently experiencing “relivings” of a past trauma world—a world that, in many cases, no longer exists.

Many clients come to therapy with “issues” and emotional problems that do not fall clearly into the category of single-incident PTSD. Oftentimes, a client’s clinical picture might include significant psychological defenses, problems in forming and maintaining relationships with others, addictive disorders, and dissociative separation between personality parts. This is a book for therapists who are trained and experienced in using standard eye movement desensitization and reprocessing (EMDR; as taught in the basic Eye Movement Desensitization and Reprocessing International Association [EMDRIA]-approved trainings), but who are stymied sometimes about how to structure therapy sessions to help clients with more complex emotional problems. The methods described in the chapters that follow are meant to supplement, not replace, standard EMDR procedures (Shapiro, 1995, 2018). The standard procedures are extremely useful and effective (Maxfield & Hyer, 2002) with a wide variety of clinical presentations that originate in or include disturbing traumatic memories. However, for some clients, those who have suffered early, complex, and prolonged abuse or neglect, additional therapy “tools”—conceptual models and specific therapy interventions—can significantly extend the therapeutic power of EMDR-related methods.
I began using EMDR in 1992. At that time, I had a practice as a therapist for several decades, with the particular focus of treating complex emotional problems—personality disorders, addictive disorders, clients with “thought disorders” and poor reality contact, and clients with histories of childhood abuse. EMDR met a need that had repeatedly come up in my work with clients. Many people who had been in therapy over the years had developed cognitive understanding of why they were unhappy, and this had helped, but part of the affective element of their initial problem had remained. One person said, “I know why I am nervous around my father, after everything that happened when I was a kid. I know all that, but when he calls on the phone, I still feel anxious, like I am 10 years old, all over again!” For many clients who endured sexual abuse or sexual assaults, the therapy process was very arduous, and for those who had gained insight into their history, but still had intense feeling of shame or fear, all I could suggest was continuing exposure to these irrational affects, either in my office or when these feelings arose between sessions.

EMDR was a solution to this problem. It was a way to break through, relatively quickly, and help these individuals tame the flashbacks and the disturbing emotions that had resulted from their prior life experience. My enthusiasm for EMDR was channeled into several research projects, work with the Trauma Recovery/EMDR Humanitarian Assistance Program, and, in my practice and in writing, exploration of ways that EMDR-related procedures could be used in the treatment of the more complex psychological disorders.

Therapists who are trained and experienced in the use of EMDR often report a particular phenomenon during the first year after their training. The composition of the therapist’s clinical practice is likely to significantly change. Those clients with simple, single-incident posttraumatic disturbance—a traumatic event that the person was depressed or anxious about, and was reliving mentally—were able to finish therapy fairly quickly, say “Thank you very much!” and be on their way. Consequently, within the practice of a newly trained EMDR therapist, there tends to be a shift to an increasing proportion of clients with more complexity in their clinical picture. The great majority of clients come to therapy with “issues,” not just of troubling memories but also of interpersonal problems and significantly problematic personality structure. Oftentimes, that is when additional conceptual models and additional procedures—additional therapy tools—are needed.

This book has two main goals: to provide descriptions of specific EMDR therapeutic “tools” and, by incorporating these tools, to develop an overview of an Adaptive Information Processing (AIP) model of the treatment of Complex PTSD. The development of EMDR-related tools has been ongoing since the introduction of EMDR three decades ago (Shapiro, 1989). Since that time, many advanced applications and extensions of the EMDR Therapy approach have been developed. What will EMDR be in 2030? Unfortunately, our field—the field of psychotherapy for trauma-related disorders—has at times had a kind of dissociative disorder. Some therapists identify with one theoretical approach, and
others are strong adherents of another identity. Often, these two “identities” do not communicate sufficiently, and sometimes they mistakenly think they have to fight with each other. Clearly, my primary identification as a therapist is with EMDR-related methods based on an AIP approach, but in each of the following chapters, I am also attempting to integrate the concepts and methods of cognitive approaches—approaches that are not only useful, but at times essential in the treatment of dissociative clients.

The use of the word “tools” is intended here to be metaphorical: a person who builds houses for a living needs to use power tools, but that person also needs to know, in general, how to build houses! A contractor or carpenter needs to know how to put up drywall, read blueprints, put in the electricity and plumbing, and so on. The tools I will be describing in this book are meant to be blended, for the reader, with other skills previously acquired as a psychotherapist.

Many EMDR therapists are quite aware of the need in their work for additional concepts and interventions, particularly when working with clients who have extensive trauma histories going back to childhood abuse and neglect. Some new EMDR therapists take the approach of alternating between “doing psychotherapy” and then putting their psychotherapy skills on the shelf so that they can “do EMDR.” Often, therapists will attempt to create a “hybrid” therapy, combining elements of EMDR with whatever therapy model the therapist was using before. This mixing of models can be useful if the therapist remains alert to the ways that the best elements of each model can be successfully integrated. But it can be problematic if the “hybrid” leaves out crucial elements of EMDR such as the targeting of specific key memories; the focused use of sets of bilateral stimulation; the identification of negative beliefs about self that are related to traumatic events; the identification of a positive, more realistic cognition about self that might replace the negative belief; and/or the emphasis on including physical sensations in the processing. Fidelity to the basic EMDR eight-phase model has been shown to be very important for the effectiveness of the method (Maxfield & Hyer, 2002), and so alterations and extensions of EMDR for therapy for more complex clients require the careful judgment of the therapist (as well as the informed consent of the client). As a general rule, we can say that, for experienced therapists, everything previously learned about how to do effective therapy prior to EMDR training—all understandings about people, all the ideas and interventions learned through reading and workshops and from previous clients—is still important, is necessary, and provides a context for doing effective EMDR therapy. The tools described in the chapters to come are meant to supplement, not replace, the skills and understandings of experienced psychotherapists.

The chapters of this book are divided into four parts. The first, comprising Chapters 1 and 2, is an overview of the application of the AIP model to Complex PTSD and other dissociative conditions. The second part, Chapters 3 to 6,
presents ways of treating (i.e., resolving) psychological defenses that are often linked intrinsically to disturbing memories but can be conceptually defined as separate entities because defenses typically contain dysfunctional positive affect, as opposed to the disturbing affect within memories of traumatic events. The third part, Chapters 7 to 14, focuses on several issues important in the EMDR treatment of dissociative conditions. And Chapters 15 to 17 are detailed case reports illustrating how these AIP “tools” can be employed in actual treatment sessions.

REFERENCES
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Share

EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation, Second Edition
The Persistence of Dissociative Personality Structure and the Internal Healing Dialogue (IHD) Procedure

Why does dissociative personality structure persist long past the time when it was adaptive as a means of coping within a difficult early environment? If human beings were completely logical, we might expect that dissociative adaptations to a difficult childhood would diminish or discontinue when that child grows up and escapes that stressful world. But, for most adult dissociative clients, the separation between parts has continued long past the childhood time when it was created, when it was needed, and when it was adaptive. Why is this? In other words, what factors maintain the dysfunctional separation between dissociated personality parts, even long after the person has grown up and has been living in the larger adult world, perhaps for decades? By definition, for individuals suffering from dissociative disorders, factors exist that are ongoing barriers to mutual awareness between parts, and once that awareness has been achieved in therapy, there are additional barriers to synthesis and merging of personality parts. To the extent that these barriers can be identified and therapeutically targeted, personality integration—typically the larger goal of therapy for an individual with a dissociative disorder—becomes much more possible.

Within the Theory of Structural Dissociation of the Personality (TSDP; van der Hart, Nijenhuis, & Steele, 2006, pp. 204–209), it is hypothesized that dissociative separation between identities or parts is maintained by a series of internal phobias—fear and avoidance that arise whenever there is a possibility or threat of coconscious connection between specific dissociated mental states. The apparently normal parts (ANPs) of the personality may have phobic fear of
disruptive intrusions from emotional parts (EPs)—unpleasantly vivid trauma memories, emotional disturbance, and trauma-related mental actions. Virtually any type of mental action may have been tainted by association with traumatic events, and in the person’s present life, those actions may now be phobically avoided. These feared mental actions may include behaviors (such as assertion, honest expression of feelings, accurate perception of past and present realities), and also include emotions (such as trust, hope, anger, shame, sexual arousal, and even fear itself). And the phobia-based distancing can go the other way. EPs of the personality may be afraid of the rejection and judgment of an ANP, and, as a result, these EPs may be angry, or “hiding,” inaccessible to the ANP.

These types of internal phobias prevent contact and integration between personality parts, and if parts are known to each other, but still separate, there is likely to be an ongoing pattern of antagonistic relationships between them. For example, the client, as ANP, might have intrusive fears that originate in the unresolved trauma of an EP, and then have an additional anger/shame with regard to these fears—“I hate it when I get afraid like that!” Or the ANP may be frightened and angry about the disruption caused by the inner voice of an EP—“I always hear this voice inside, telling me I’m no good. I start to feel confident, and then that tears me down. I hate that voice! I wish it would just shut up and go away.” Conversely, EPs may be angry at an ANP for keeping them in exile, never allowing them to “come out,” and perhaps never even wanting to acknowledge their existence. These phobias, leading to internal conflict, are a primary factor in maintaining dissociative personality structure, long past the time when that structure was adaptive.

Unrealistic and inappropriate idealization, in various forms, may be an additional contributing factor maintaining dissociative disconnect between parts. Idealized (i.e., unrealistically positive) images are often pleasing within themselves and are valued for that reason. In addition, though, idealized images often serve a defensive purpose—one of preventing the emergence of disturbing, traumatic memories (as described in Chapter 5). Rigidity of personality structure can result when a certain part has the task of shutting out all threatening, reality-based information that might undermine an overvalued mental image. For example, one part may be highly invested in maintaining an unrealistically positive image of one’s father, thus blocking conscious access to memories of maltreatment by the father. This creates an internal impasse, with resulting confusion and dysphoria on the part of the ANP. In other words, the ongoing dissociative disconnect between parts may be maintained because of an idealization defense, and, in addition, there may be dissociated parts that function to prevent an idealization defense from being tainted by certain realities and/or memories of traumatic experience.

Another element often maintaining separation between dissociative parts appears to be the phenomenon of Learned Helplessness. In a variety of research studies (e.g., Seligman and Maier, 1976), it was demonstrated that people, or
animals, that are trapped in an inescapable place of repeated punishment are very likely to develop attitudes of helplessness and submission regarding their options after a period of time. In other words, it is hypothesized that repeated aversive experiences of helplessness diminish attention to, and awareness of, choices. This research is directly applicable to the situations of many clients with Complex posttraumatic stress disorder (PTSD), who grew up with ongoing, inescapable adversity. For these clients, their condition may have elements not only of sympathetic arousal, but also dorsal vagal parasympathetic activation (as described previously in Chapters 7 and 12), together with cognitive and visceral elements of self-shaming. Learned helplessness impairs not only hope but also the mental energy needed to reconcile the internal conflicts and incongruities of separate dissociated parts. If an infant’s intrinsic attachment behaviors were repeatedly frustrated by nonresponsiveness or frightening behavior from caretakers, the infant may have developed a response of helplessness with regard to meeting attachment needs. The child’s natural propensity to learn to attach to, and enjoy, other people may have been thwarted. Instead, separate self-states may have been developed as adaptations to the needs and stress-inducing behaviors of adults, as described in Chapter 7. If these events occurred preverbally, they may not be consciously accessible to the adult dissociative client living in today’s world, but they may be a factor in perpetuating that client’s internal structure of nonintegrated parts.

In a related way, defensive shame about self can be an obstacle to personality integration. One client, with a history of sexual abuse, said, “I can’t let myself think of what might have happened. It makes me feel so ashamed!” Shame feelings frequently arise during therapy when an adult client is accessing memories of positive attachment to the perpetrator (Ross, 1998). The eye movement desensitization and reprocessing (EMDR) targeting of this type of shame defense was previously described in Chapter 12.

Blocking beliefs (such as those listed in Chapter 6) can stand in the way of personality integration. In general, blocking beliefs express a certain divide or unresolved discussion between personality parts (with ongoing conflict between different needs, different orientations, different agendas). One part holds the belief, while another part wishes to advance in therapy toward a desired goal.

For some dissociative clients, personality integration will occur spontaneously when the posttraumatic disturbance, held internally, within parts, is resolved and no longer overwhelming. For these clients, the need for protective dissociative distance between parts thereby becomes less needed. For example, in Chapter 15, the client, Veronica, shows this type of spontaneous integration at the end of a successful therapy session focused on resolving a posttraumatic distortion of a child EP.

For other clients, however, the dissociative distance between separate first-person identities is maintained even after significant trauma processing has
occurred. The continued sense of separation between internal parts may con-
tinue due to hidden unresolved memories, hidden internal phobias, ongoing
anger between parts, denial defenses, strong avoidance defenses, idealization
defenses, and shame/helplessness defenses. It may not be clear to either the
client or the therapist why this continuing dissociative separation is occurring,
but the client may be very frustrated by this situation. In these circumstances,
appropriately focused sets of bilateral stimulation (BLS) can be potentially quite
helpful in identifying and therapeutically targeting barriers to personality inte-
gration, and safely lessening the dissociative distance between parts.

THE INTERNAL HEALING DIALOGUE PROCEDURE

What is being proposed here is an extension of the use of BLS to help disso-
ciative clients who are frustrated by the persistence of dissociative separation
between parts, even following significant therapeutic reprocessing of post-
traumatic disturbance. A client may wish to achieve personality integration for
many reasons—for example, to “finally know who I really am,” to be able to
live in the world authentically without hidden feelings or motives, to no longer
have the confusion of being pulled in different directions by discrepant parts,
and to be able to truly regard oneself as a “normal” person, with a deep sense of
self-acceptance with regard to all of the adaptations that were necessary to cope
with traumatic circumstances earlier in life.

Even if therapy has progressed to the point that now there is some degree
of mutual access—simultaneous awareness, each part of the other—the parts
may still have intensely different perspectives, and a variety of negative feelings
with regard to each other. Internal healing dialogue (IHD) is used when the cli-
ent has progressed to have sufficient orientation to the safety of the therapist’s
office, and is able to observe the internal parts that remain in some type of
conflict or standoff. Using language from the Structural Theory of Dissociation
(van der Hart et al., 2006), the client now has sufficiently elevated “mental level”
and sufficient “presentification” to be able to know the experience of one part of
Self, and then shift into knowing the experience of another separate part of Self.
Using language from the Internal Family Systems model (Schwartz, 1995), the
client is looking at internal personality parts from Self, and Self is assisting in a
“leadership role,” directing therapy toward personality integration.

The Back-of-the-Head Scale, described in Chapter 13, can be useful in
assessing the client’s ability to achieve this place of present orientation and
safety. This is a place of mobilization of the client’s natural, intrinsic Adaptive
Information Processing (AIP) system. The therapist’s role in using the IHD pro-
cedure is to exert a steady influence to help the client maintain orientation to
present safety, and assist each of the conflicting parts in self-expression, and in
listening (similar to what would happen in couple’s therapy, when a therapist
assists two separate people to improve their skills of respectful clear expression
and active listening). For the great majority of dissociative clients, this type of
healing internal conversation has been prevented in the past by impulses of fear, avoidance, anger, indifference, learned helplessness, and so on. The IHD between parts may initially be quite contentious, but nevertheless productive, because it can facilitate resolution of a lifelong dilemma. Often this is an internal conversation that never happened before!

IHD generally begins through use of Loving Eyes procedures, as described in Chapter 11. When Loving Eyes procedures are used directly, as described in that chapter, the ANP visualizes a child EP. In some instances, the ANP will have a compassionate and positive feeling as an immediate response, towards the EP child part. But just as often, the opposite will occur—some type of defensive process will emerge—for example, a fear of that child, denial of a traumatic event, a wish to avoid thinking of the child, or a shaming dislike of the child. The therapy session can then be devoted to processing (reducing the intensity of) whatever defensive action is occurring, and then resolving the underlying traumatic material.

The use of Loving Eyes in order to resolve an internal conflict involves suggesting to the client that he or she create a representation of each side of the conflict. The therapist must remain alert to whether the client is maintaining sufficient present orientation and safety when carrying out this task. The original developer of an EMDR-related method of integration of parts is Robin Shapiro. Her two-hand interweave procedure (Shapiro, 2005) involved the client placing one conflicting feeling, thought, choice, belief, or ego state in one hand, and another in the other hand, and then simply beginning sets of BLS, with the client reporting, after each set, any shift in emotion or perception of the parts. If information or feelings in one hand or the other is distressing, that distress can be targeted using the standard EMDR protocol. This method is very flexible in its application to a wide variety of clinical situations in which different mental states are incompatible or in conflict. It is very helpful to many clients—a direct perception of two hands can then serve as a reference point in speaking about two different personality parts. By placing each part in the client’s own two hands, the implicit (perhaps subliminal) message is taken in—“These are both part of me.

Alternatively, the therapist may present his or her own hands, with palms facing the client, to represent the client’s personality parts. A possible advantage of using the therapist’s hands is to introduce dialogue interweaves—“One part of you says this (therapist wiggles left hand) and then, what if the other part of you would reply by saying . . . (therapist wiggles right hand)? What would this part (wiggle left hand) say in reply?” Other possibilities: The client or the therapist can make a drawing on a page showing separate ovals or scribbles to indicate the conflicting parts. Then, as the dialogue proceeds, the therapist or client can point to each of the places on the page to refer to each of the internal states. Dissociative table imagery (Fraser, 1991, 2003; described in Chapter 10) can be used, with a large imagined video screen on a wall to show visual memories, different chairs at a table to indicate the different parts, and a microphone that can be handed back and forth between the parts to reflect which part is speaking.
When the representation—hands, drawing, or dissociative table—has been established, and a visual memory image of the internal conflict or disagreement has been identified, then, with the memory image in mind, the therapist asks one of the two conflicting parts to express as clearly as is possible that part’s point of view regarding the memory. For example, one part might say, “I don’t know if it really happened. I don’t think it really happened.” Whatever is spoken by the client, the therapist initiates a set of BLS, with words like, “Notice that” or “Stay with that.” Then, the focus is shifted and the other internal part/identity/ego state is asked, “What is your reply to that?” That part might say, “I don’t want to think that it happened, but I have pictures in my mind of every detail. I think it did happen.” This reply is then followed by an additional set of BLS. Then, the first ego state is asked to reply to the reply, and again this is followed by a set of BLS. Defenses may arise, and these can be targeted and resolved. Parts may have polarized in the past, and one or both may be rigid in adherence to a particular point of view. When this occurs (and it often does), there’s often a fear of overwhelm or of loss of control that is driving the rigidity. This can be addressed in a number of ways; for example, “What are you afraid would happen if you gave validity to what that other part is saying?” Previously dissociated memories, held by one part or the other, may become apparent, and these can be the focus of processing. As this procedure continues, the typical result is a shift in perspective, and a gradual reduction in the fear and antagonism that has prevented this internal dialogue in the past. The client is likely to become less frightened of continuing the dialogue, and more aware of contextual information that was previously unavailable to these conflicting parts. This is similar to what occurs in normal, trauma-focused EMDR when the client benefits by feeling less disturbance while becoming more aware of the larger context of a traumatic event.

Within the field of psychotherapy, it is hardly new to ask different, separate personality parts to talk to each other as a means of healing inner conflict and facilitating personality integration.

This approach has roots in psychoanalysis, and was further developed by Moreno (1969) in the context of psychodrama; it was also part of the “empty chair” method developed by Perls (1951; Polster & Polster, 1974) in the context of Gestalt Therapy. What do focused sets of BLS add? As described in Chapter 2, BLS, when paired with consciously held emotionally charged memory material, will tend to expand associational connections, reconsolidate the memory material to a form that is more consistent with past and present realities, reduce sympathetic arousal, reduce the “aliveness” and vividness of “reliving” aspects of the memory, create more emotional “distance” between Self-as-observer and the content of the memory, and assist the client in using productive and mindful “slow thinking” instead of reactive “fast thinking” to process the memory. Each of these BLS effects contributes to EMDR’s well-documented effectiveness with disturbing trauma material. As described in Chapters 3–6 and in Chapter 12, focused sets of BLS can also facilitate the resolution of psychological defenses. We can hypothesize that appropriately targeted sets of BLS can also contribute to the
reduction of the mental actions (phobias, avoidances, and idealizations) that maintain entrenched differences and conflicts between dissociative personality parts. This resolution can, in turn, facilitate movement toward personality integration.

As described in Chapter 9, a commonly observed example of conflicting internal parts, in the presenting picture of dissociative clients, is the “attachment to the perpetrator” problem (Ross, 1998). The client’s “Adult” part may have fear, avoidance, anger, and/or shame with regard to a child part who suffered abuse at the hands of a caretaker. And parts can have parts. Within the child part, there may be one self-state that hates the perpetrator, while another self-state may be highly invested in continuing to idealize—think positively of—that perpetrator. This conflict in perspective—intense anger versus positive attachment—within the child EP may have previously blocked any internal discussion that could have resolved the actual reality of how the perpetrator was (back then) and is (even in the present). This conceptualization may be threatening to many clients, especially in the early stages of therapy, due to the “idealization of other” self-state being completely dissociated. Figure 14.1 shows ovals representing a possible personality structure for a client who has resolved ambivalence by dissociating the positive attachment to the perpetrator(s).

If the clinician suspects that a client has this complex dilemma, it is typically important to help the client discover this internal situation on his or her own, either (as Ross does) through cognitive restructuring/Socratic dialogue or during IHD procedures. If a therapist prematurely tries an interpretation—for example, “Perhaps, in addition to your hatred of your abusive father, you also have a positive attachment to him”—many clients will regard this interpretation...
as pretty lousy therapy, and may go looking for another therapist. The case example in Chapter 17 illustrates a more graded approach—specific ways of using the IHD procedures to help a client reach a full realization of a dissociated idealizing self-state. Once the client has this realization, the internal dialogue can proceed to help the client find resolution to the “attachment to the perpetrator” problem.

This split may take another form, as illustrated in Figure 14.2. The positive attachment may be held by a consciously available self-state, perhaps merged with the ANP, and the trauma memories and negative feelings toward the perpetrator may be entirely dissociated. In these instances, it is not unusual for the client to show not only a positive attitude toward the perpetrator, but also a tendency to irrationally take on excessive responsibility—even shame—for frustrations that occurred in the relationship with the perpetrator (Knipe, 2009). Again, premature interpretation of these dynamics by the therapist may be counterproductive. Strong idealization defenses may have been established very early, as a necessary element of the very young child’s bonding with a parent. A client’s idealization of this bond may be strongly entrenched because it has pushed from awareness memories of neglect, abandonment, and betrayal.

As the reader might imagine, there may be complexities, twists, and turns in the course of this dialogue, just as occurs when two adults are attempting a conversation to resolve a complex and emotion-laden disagreement. Emerging attitudes of intransigence of one or both parts may be grounded in initially hidden defensive processes and/or unresolved posttraumatic disturbance. The ANP

![Figure 14.2](image-url)
may have memories of intense and unwelcome intrusions of highly disturbing posttraumatic material, and this may be driving a very strong avoidance urge. There may be a lifelong conviction of shame about self (“I am just a bad person,” or, as one person said, only half joking, “I just decided a long time ago that I have to accept that I’m guilty of everything!”) along with an intense wish to continue a strong idealization of a perpetrator. There may be a strongly felt reluctance to really know the depths of grief regarding childhood abandonment. Hidden unfinished trauma material and/or defenses may be blocking the dialogue. Over the course of therapy, each of these elements can be targeted in turn as they arise, with vigilance of course, regarding the maintenance of present orientation and safety.

In several of the session transcripts in this book, this type of healing dialogue, facilitated by sets of BLS, can be seen. In Chapter 17, a therapy session is described that illustrates in detail the use of IHD procedures.

REFERENCES


