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CHAPTER 6

Loving Eyes

Procedures to Therapeutically Reverse Dissociative Processes While Preserving Emotional Safety

Jim Knipe

ONE FOOT IN THE PRESENT, ONE FOOT IN THE PAST

A client with a history of severe traumatization and a fragmented sense of self recently said to me, "This time, therapy has worked for me, because now I can come back and be present here in the room. Previously, feelings would get stirred up, and then I would dread the next session. In the past, I've had no trouble going into my memory of what happened. It's been way too easy. It's been like sliding down a slippery slope. The hard part has always been coming back. In here, I've been able to come back."

Dual attention (simultaneous awareness of both the disturbing material and a neutral or safe aspect of the present situation) is an essential element of the effectiveness of EMDR (Shapiro, 2001). That is, in EMDR therapy, the therapist assists the client in keeping "one foot in the present, one foot in the past." Metaphorically, "two feet in the past" would simply be emotionally reliving the trauma, and not therapeutic. For those clients with highly dissociated and intense affect, there is a danger with standard EMDR that uncontrolled emotion may intrude into consciousness in a way that undermines this important balance between present and past. In this chapter, several methods are described that seem to be useful in empowering clients with dissociated ego states to stay

oriented to the present while processing unfinished disturbing memories. Specifically, these EMDR variations seem to enable the client to maintain the balance between emotional safety and the controlled emergence of unresolved affect, so as to avoid dissociative abreaction and make possible the healing and eventual integration of separate parts of the self.

For many client situations encountered in clinical practice, the concepts of ego state therapy seem to be a natural adjunct to the EMDR Adaptive Information Processing model (Forgash & Knipe, 2001). In 1871, the poet Walt Whitman expressed a truth of the human condition in his *Song of Myself* when he wrote, "I am multitudes." In general (and to varying degrees between people), different and distinct "states of mind" often coexist with a single individual's personality, and these different ego states may have separate histories and be experienced subjectively as distinct from one another.

Another variable is one of experiential distance between separate ego states. Different ego states may either be relatively co-conscious (Watkins & Watkins, 1998) or be so dissociated from one another that there is very little mutual awareness between these states. If these parts of the self are repeatedly in conflict, or working at cross-purposes, the result can be an ongoing experience of dysphoria and low self-esteem. For example, an adult ego state might be highly motivated to block and avoid the activation of a child ego state that carries the fear, horror, and other affects associated with a traumatic event.

When posttraumatic disturbance is triggered by a present-day situation, the intrusive images and feelings from the memory tend to have a "right now" quality—a sense of living the trauma again—that can give the adult feelings of disorientation and loss of control. If the adult self strongly identifies with the wish to escape from, disown, or obliterate the unpleasant affect, then the problem tends to remain locked in place, with an ongoing experience of helplessness and depression. The memory material is pushing for expression in awareness; the adult self is blocking this expression. This type of self-defeating deadlock can lead to ongoing shame and depression: "What is wrong with me?! I should be able to just get over this!" For clients who are at cross-purposes with themselves in this way, I will often tell the following story (with the child the same sex as the client).

> Imagine a little girl who falls down and skins her knee, and it hurts. Her knee is bleeding and she runs into the house. A loving parent sees her and says, "Oh, it hurts, doesn't it? Come over here. Let me wash it off. Yes, it hurts! I'll put a bandage on it. Come sit in my lap for a little while." It is easy to see that after a few minutes, for this little girl, this lap will become pretty boring, and she will want to go back out and play again. If the parent asks her if her knee still hurts, she is likely to

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EMDR AND DISSOCIATION

There is clearly an element of dissociation in posttraumatic stress disorder. Even in the case of single-incident PTSD, there are two relatively dissociated ego states: one that is aware of present safety, and another that has a sense of felt reality about intrusive flashbacks or hyperarousal associated with the traumatic event. Generally, the purpose of therapy for PTSD is to reverse this mild dissociation, integrate the two ego states, and transform the disturbance into a completed declarative (narrative) memory (van der Kolk, 1994). The trouble is that the standard EMDR protocol, much more than other psychotherapy methods, tends to invite dissociated memory experience into present consciousness (Lipke, 1994; Paulsen, 1995). This, of course, can be a very good thing if the individual is able to maintain orientation to the present safety of the therapist's office while the disturbing material comes into consciousness.

But for a client with severe dissociation between separate ego states, the abrupt emergence of dissociated affect has the potential to be startling, disorienting, and retraumatizing. For example, in the story above, what if the little girl now grown up had put out of awareness all of the times that her feelings had been invalidated by that parent, in order to preserve in her mind a highly valued and positive picture of a loving and nurturing home environment? What if this little girl's story had also included even more extreme abuse and neglect? These factors increase the risk of uncontrolled and nontherapeutic abreaction.

In these situations, then, it is very important to counter this risk with an increased emphasis on safety and containment of affect. The client and therapist, in partnership, "go fast by slowing down." In other words, the more traumatized and dissociative the client, the more important it is that concerns of emotional safety and affect containment be an integral part of the treatment process. This concern regarding safety has

many implications in the overall planning of treatment for a dissociative individual, and the implementation of that treatment (Forgash & Knipe, 2001; Kluft & Fine, 1993; Putnam, 1989).

This chapter presents three cases, all of which show a method of containing affect and reconciling conflicted ego states through what I term "loving eyes." The second case illustrates a method of targeting avoidance defenses, and the third example shows the procedure of Constant Installation of Present Orientation and Safety (CIPOS; Knipe, 2002) as well as the Back of the Head Scale (BHS; Knipe, 2002), a measurement tool that is useful in assessing a client's moment-to-moment level of dissociation. All of these session transcripts are derived from video recordings that were made as EMDR training tapes. In all three instances, the clients have generously given their permission for their session to be described in this chapter. The dialogue here is repeated verbatim except for minor editing for clarity and alteration of identifying information.

LOVING EYES: SEEING THE TRAUMATIZED CHILD

Active visualization, guided and contained by the therapist, may be used to create an emotionally safe connection between dissociated ego states. Often, just as in normal daily interactions between people, the language of visualization is a part of the expression of mutual understanding. One friend might convey concern and acceptance to another by simply saying, "I see. I see what you mean." To "see" the troubles of another person is to provide comfort for the troubled individual; it is a connection and a sharing of experience. In addition, the word "seeing" also connotes a certain distance—a buffer of separation for the one who is empathizing. Those clients with dissociated ego states who are able to "see," from one state to another, can experience a sense of protective separation from their own disturbing affect, a grounding in emotional safety, while also connecting, reconciling, and resolving disturbing memory material.

In addition, it seems that for many clients with extensive childhood histories of abuse and neglect, a major element of their dilemma was that their deepest needs and feelings were not "seen." That is, their inner experience was not lovingly acknowledged, and thus validated, by a caretaker. This lack of validation of inner experience is hypothesized (Linehan, 1993, pp. 51–52) to contribute to the emotional pathology of adults who have difficulty regulating their own affect (as with borderline personality disorder and other related conditions).

The EMDR treatment methods described below are based in part on the speculation that the "loving eyes" of an adult are often an essential element in the process of healing from childhood trauma. It is certainly

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a necessary element of therapy that the clinician view the client with positive regard (Truax & Carkhuff, 1967). One hypothesis (Schore, 2000) is that the therapist's positive regard is not only necessary, but also sufficient to heal the damage caused by childhood abuse and neglect. It is often the hope of a client who experienced neglect that the therapist will be the mother or father the client never had. Indeed, for many such clients, the reparative work that occurs in the transference is, in fact, a primary element of their healing. But for clients with intense dissociative processes, it seems an additional step is necessary. For these clients, it is often useful for the therapist to assist the client in strengthening the part of the self that is oriented to present reality, and then assist that present-oriented ego state in witnessing the painful affect held in a dissociated child ego state. Oftentimes, the affect within a child ego state has never been compassionately observed, either by another person or by another part of the self within the personality system.

In working with clients who have this particular difficulty, I have found it useful to use a procedure that I call Loving Eyes. Years ago, a client with a dissociative disorder asked a peculiar and provocative question: "How do most children grow up from four to five?" (This client suffered horrible abuse and neglect at age four.) "When I was four, I wanted to grow up to be five, but I couldn't do it, so I made a 'box,' with the real me inside, and a happy face on the outside of the box so that everyone would think I was normal. But now the part of me that is still four wants to grow up. How do other children grow up to be five?"

We focused on this important question for several sessions, and finally a principle became clear—a principle that has since been confirmed with many other clients—that the reliable loving eyes of an adult seem to be important, perhaps essential, for the emotional growth of a child and the maturation of that child's identity. In contrast, a child who grows up in a world that is devoid of loving eyes (a neglectful, emotionally unresponsive environment) will be compelled to focus awareness on the fragile thread of connection to that environment. That is, the child will place all importance on adaptation, at the expense of inner needs and emotions. The child's sense of self may split into an adaptive "box" that faces the world and attempts to "look normal," and another little secret self inside that holds the feelings that the child's environment cannot tolerate.

If, within a disinterested and neglectful world, the child also experiences specific trauma, that is very likely to make the dissociative split much worse. A child in these unfortunate circumstances may grow up with an overemphasis on adaptation and a sense that many internally experienced needs and feelings are unwelcome and ego dystonic. Of course, this can result in many emotional difficulties in that individual's adult life.

For adult clients who come to therapy with this type of background, the Loving Eyes intervention has frequently been useful. The steps in the procedure are as follows:

Step 1. Find a visual image, preferably an actual memory, that represents the ego-dystonic affect. The adult client, reminded of being an adult, sitting in a therapist's office, is asked to visually witness the childhood event, *as a separate person from the child.* Usually a memory image can be identified with a simple question such as, "When you were a child, were you ever afraid?"

Step 2. If the client has trouble clearly accessing an actual memory, the therapist can speak to the client in way that identifies a memory via an affect bridge (Watkins & Watkins, 1997), by saying, "When you notice where that fear feeling is in your body, and take that back to when you were a kid, what do you get? Just take whatever you get." Most clients will then begin to form a memory picture. This picture can then be clarified with specific questions such as, "Is this child inside or outside?" "How old is he?" "What room is he in?" "What is he looking at, when you see him right now?" It is important to ask these questions in a general way (that is, not leading the client to respond in a particular way).

Step 3. Ask the client, "Sitting in this chair, the adult you are today, can you just look at that child?" If the client says "yes," the therapist initiates eye movements, with words that are open and permissive, such as, "Just see this child. When you see this child, *just see whatever you see.*" The therapist's wording conveys acceptance of the child, without judgment. This type of unconditional acceptance is probably what the child needed at the time of the original traumatic event. It frequently occurs at this point that the adult ego state begins to experience the feelings of the child, and so the therapist must take care to ensure that these feelings are contained within the adult's sense of present safety. Sometimes it is necessary to pause in this process, so that the client will stay oriented to present safety.

Step 4. It often occurs that the adult client initially has a nonaccepting reaction to this image of the childhood self. For example, as in the first case below, there may be a lecturing or scolding reaction, or, as in the second case, a reaction of embarrassed avoidance. These negative reactions to the child represent defense, which remains in place in order to maintain dissociative distance from the painful affect that is held within the separate, frightened, child ego state. Because the negativity is a defense, it will generally

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process with eye movements if the client is asked to focus on the positive feelings (relief, containment) associated with the avoidance defense. For example, in such instances, the therapist might ask, "What's good about not looking at that child?" In response to this question, the client might say something like, "If I look away, I don't have to feel those feelings," or "If I don't look, I don't have to see how awful it was." Often, disgust with the childhood self is an adaptation that was necessary at the time of the trauma, a way of allying with a powerful perpetrator in order to not be totally abandoned. Whatever the client's response, the therapist can then respond, "Think of that" accompanied by bilateral stimulation. Very frequently, the avoidance urge lessens and the resistance to compassionately seeing the child is very likely to diminish. This procedure is described and illustrated in the second session transcript, below.

Step 5. When the client is able to freely see the child, the therapist may then ask, "When you look at that child, can you see the child's feelings?" Usually, the client will acknowledge that the child's feelings can now be seen, and at this point the client notices beginning to share the feelings of the traumatized child. As sets of bilateral stimulation continue, with sufficient continuing orientation to present safety, the fear will dissipate and positive feelings of connection and compassion for the child are likely to increase.

Step 6. As the client begins to speak of the child compassionately, the therapist can ask, "When you look at that child, how do *you* feel about the child?" The client may be surprised to discover the possibility, as an adult, of viewing this child with love and respect. The child part can then begin to experience this love and validation. Another question for the client might be, "Is there anything that you know, as an adult, that would be helpful to that child? Something that child doesn't know?" Whatever the client answers to these questions, the therapist can respond by saying, "Stay with that," and apply additional sets of eye movements. This internal dialogue typically continues to a point of healing resolution.

Step 7. If the client says that the child is "scared that we see him," or "is worried that we will criticize him for being afraid," then the shift should be back to the adult self with questions like, "Do you in fact, as an adult, looking at the child, feel critical of the child for having that fear?" It may be necessary to go back to Step 5, above. Interweaves of cognitive information about the realities of the child's life circumstances are often useful in softening the

harshness of the critical adult's perspective (for example, "Do you think that child has it rough?").

MEHMET: DISSOCIATED AFFECT DUE TO CHILDHOOD DEPRIVATION

The first case illustrates the use of the Loving Eyes procedure. In 1999, following a series of catastrophic earthquakes in Turkey, the EMDR Humanitarian Assistance Program (HAP), in coordination with the Istanbul branch of the Turkish Psychological Association, began a project of EMDR trainings for Turkish therapists who were voluntarily providing services to people suffering from PTSD following the quakes. The following transcript is from a therapy session with Mehmet, a forty-three-year-old man who was horribly traumatized when his apartment building nearly collapsed during the initial earthquake in August 1999. For a seemingly never-ending period of forty-three seconds, in the middle of the night, he felt certain he was going to die. He was able to escape to the street, but then reentered the dangerous and totally dark apartment building to rescue members of his family. In the hours after the quake, he learned of the deaths of several friends and acquaintances. In October 1999, Mehmet volunteered to undergo EMDR with a member of the HAP training team (with the help of a translator), and he generously agreed to allow his sessions to be videotaped to provide a demonstration of the method to the Turkish trainees.

At the time of his first EMDR session, he reported very disrupted sleep since the night of the quake. (He actually said he had "not been able to sleep at all.") Whenever he would close his eyes, he would begin to relive the worst moments of that night. After two sessions of EMDR, his nightmares and his waking visual flashbacks had significantly diminished, and he reported that he no longer experienced any emotional disturbance during daytime hours. However, at bedtime, he was still experiencing hyperarousal with spikes of panic in response to unexpected environmental sounds such as a door shutting in his apartment building, a refrigerator coming on, and sounds in the street below. He then would have difficulty going to sleep, as well as a racing heartbeat and sweaty palms. Because the initial sessions of standard EMDR had been only partially successful in helping him, he requested an additional session.

It was not surprising that Mehmet was continuing to have trouble at nighttime, since the initial earthquake had occurred at night. When I met with him, it was late afternoon, and he insisted that at that hour, he was not having even a trace of fear, that he was completely free from disturbance of any kind. In spite of this absence of present disturbance,

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he stated that his difficulty at night was a desperate problem, and he hoped that EMDR could somehow help him get over it, as it had helped previously with his flashbacks and nightmares. His affect in our session was very depressed, and he would spontaneously express his frustration and disgust with himself, that he couldn't "just get over it" and rid himself of this ongoing dilemma. He said, "I hate this fear! I say to myself, 'There is no reason for it. I shouldn't have it.'" For me, these statements raised the question, Who is the hater and who is the hated? In other words, his statements suggested an ego state conflict between a part that continued to hold posttraumatic fear from the earthquake, and another part that had hatred for this ongoing fearful response.

The following excerpt shows the EMDR work with these conflicted ego states. First, visual imagery is suggested to clarify the origins of this problem, and then the Loving Eyes method is used to facilitate communication, mutual understanding, and reconciliation between these parts of the self in order to help Mehmet resolve his depression and his specific bedtime problem.

THERAPIST: When you hear the sound of the refrigerator starting up in the night, and it startles you, what thoughts are you thinking?

CLIENT: I want to throw away this feeling of fear inside me. I want to be relaxed; I don't want to bring these things back into my mind. No matter how much I try, all of a sudden a small something brings it back to my mind again. Inside, I feel this fear has not yet come to an end. I talk to my mind. I talk to myself, and say, "Am I just making this up? Why can't I get rid of it?"

THERAPIST: Do you talk to yourself harshly like that?

CLIENT: Yes, naturally. Why do I put these things into my brain?

THERAPIST: So you have the fear and then you say to yourself, "Why do I still have this fear?!"

CLIENT: Yes.

Finding the Dissociated Ego State

In order to access and clearly differentiate the ego state holding the fear, I help Mehmet remember a childhood experience of fear.

THERAPIST: When you were a little boy, were you afraid sometimes?

CLIENT: When I was a little boy... we grew up without a mother and father. I never met my father. I was born after he was dead. My mother died when I was nine and we were in poverty. My brothers and I, we are six all together. I am the youngest.

THERAPIST: Can you remember a time, when you were a child, when you were afraid? Most children have fear at one time or another. Was there a time when you were afraid?

CLIENT: [*Long pause*] In our country place, I had to take the cattle out to the field, and when I was bringing them back, and it was getting dark, I saw on the body of the animal a figure, a long something.... But later on I didn't have these things, these feelings.

THERAPIST: Are you able to think of that right now, when you saw something on the cow?

CLIENT: I see it often, and it's like a giant... like something that is dead. It's like a giant figure.

THERAPIST: As you see it now, is it uncomfortable for you?

CLIENT: No. It is nothing. It doesn't affect me, but in my childhood I had fears like this.

We might say that Mehmet cannot allow himself, as an adult, to experience the irrational fears of his childhood. But he is able to *observe* the fear, in the present, and he states, "I see it often," suggesting that this fear memory remains unresolved, though dissociated.

Reversing the Dissociation

To help Mehmet begin to make a connection with his unresolved fear, I ask him to visualize his frightened childhood self.

THERAPIST: Try to use your imagination right now to see this little boy who is bringing the cattle back, and it's dark now, and he has fear. Can you see this little boy right now?

CLIENT: I do.

THERAPIST: How old is he?

CLIENT: Ten, twelve.

THERAPIST: Can you see his clothes?

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CLIENT: I do.

THERAPIST: Can you see how his hair is?

CLIENT: I do. His clothes are torn and he is not well groomed.

THERAPIST: See this boy right now, and just see him while you watch my fingers go back and forth. [*Very slow eye movements, while I continue speaking*] And when you see him, see whatever you see, right when he is frightened and sees the cow. He sees something big on the side of the cow. And just look at him. That's good. Can you see his feelings?

CLIENT: I do.

THERAPIST: Just think of that. And see whatever you see when you look at him. [*Eye movements, while I continue speaking*] That's good. When you see this child, if you could go back in time, the man you are today, and go to that boy and tell him something that would help him with his fear, something you know that he doesn't know, that would really help him, what would you say to him?

CLIENT: I could have told him there is nothing there, don't believe in these things, don't be afraid.

THERAPIST: Stay with that. [*Set of eye movements*]

Even though these first words from Mehmet to his childhood self are somewhat judgmental and not very validating of the child's fears, it is a step in the direction of increased communication and reconciliation. In other words, he is slowly and safely reversing the dissociation that was necessary during his childhood to contain his fear. We can assume that the bleakness of his circumstances as a young boy made it impossible for him to fully experience and process his childhood anxiety.

THERAPIST: Good, think of that and in your mind, tell him now. [*Set of eye movements*] And what if this boy said back to you, "But it seems like there is something that's so scary?" What would you say to him then?

CLIENT: Don't believe in these things. There is nothing there. I would try to persuade him. [*Eye movements*]

The word "persuade," while still connoting a difference of opinion, also contains a recognition that the child's fears do in fact exist.

Activating the Nurturing Response of the Adult Ego State

The next question I pose to Mehmet is very important, in that it requires him to decide whether to continue to disown this child ego state, or begin to lovingly reconnect with this part of himself.

THERAPIST: When you look at this boy, how do *you* feel about him—the boy in your mind—when you think of this?

CLIENT: I pity him when I look at him because he is without a mother and father. [*Begins crying*]

THERAPIST: Think of that. [*Set of eye movements*]

CLIENT: He has reasons to be afraid.

THERAPIST: Think of that. [*Set of eye movements*]

CLIENT: If I could go back in time I would hug him and kiss him with love and make him get rid of this fear.

THERAPIST: That's right, think of that. [*Set of eye movements*] If you could, would you like to take this boy away from this place and bring him into today with you?

CLIENT: Yes.

THERAPIST: So, you would know how to take care of a boy like this?

CLIENT: Yes, I would make him grow without making him sad or afraid, not in the slightest bit.

THERAPIST: And if this boy sometimes heard a refrigerator sound or heard a door slam in the night because he is still scared, because of where he has been, would you get mad? Would you get angry with him?

CLIENT: No.

THERAPIST: Think of that. [*Set of eye movements*] You know, the truth is that this boy no longer exists... because he grew up into you, into being you. But in another very real way, perhaps he is still with you, right now in this room, and at night when there are sounds. Is this boy with us here today, as we talk about these things?

CLIENT: Yes, he is.

THERAPIST: So, if tonight there is the sound of a refrigerator or a door slamming, or a sound in the street, and there is fear, and your heart is pounding, try to remember

RAUMA AND DISSOCIATION

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CLIENT: I will remember myself as a boy.

At the end of this session, Mehmet said that he no longer felt anger at himself. In the weeks that followed, he was seen by his regular therapist, and it was reported that Mehmet found it very comforting to return to the image of the frightened boy and realize his own ability to soothe the feelings of his childhood self. This image, of a moment of childhood fear, was now a positive resource for him. Several months later, his therapist relayed the information that he was "sleeping like a baby" and was no longer troubled by his previous depression or emotional reactivity. When I was able to talk with him one year later, Mehmet reported that his previous symptoms remained resolved.

In this example, a memory image from childhood served as a point of access to the ego state containing the fear, but if no such memory had been accessible, another image from Mehmet's adult life (for example, of being frightened during the worst moment of the earthquake) could probably have been used. The main criterion is that the image somehow includes the affect that the individual is resisting or has pushed out of awareness. However, because these patterns of ego state conflict are usually set in motion during childhood, the most potent images would generally be of childhood fear or loneliness. For Mehmet, there was no place in his childhood world for fears, so these fears, when they nevertheless naturally occurred, had no place of acceptance within himself. Thus, he had to dissociate his fear as a last-resort method of regulating this affect. When this dissociation was reversed, with emotional safety, he was able to discover a new and more effective way of soothing his fear.

VERONICA: TARGETING AN AVOIDANCE DEFENSE

The above procedure created what Mehmet originally needed as a child—an accepting adult witness to his fears. Mehmet initially had a mildly negative reaction to the image of his traumatized childhood self. His judgmental attitude lessened and dissolved as processing continued, but this result does not always occur. Sometimes, in contrast, the client's adult self will persist in a strong negative reaction toward the image of the child in the trauma. The traumatic memory material is threatening to the stability and functioning of the adult, and in spite of the client's strong wishes to heal a particular traumatic memory, there may also be simultaneous and very intense avoidance urges when the person attempts to think of the childhood traumatic events.

When this situation occurs, the individual's avoidance defense may be the best point of access to healing the traumatic material. An avoidance impulse may be the front door into the client's dysfunctionally stored memory network, and as such it is an aspect of the client's experience that can be targeted using the Adaptive Information Processing model (Knipe, 1995, 2005). The therapist asks questions that direct the client's attention, not to disturbing affect, but to positive affects (typically relief or containment) associated with the avoidance. Specifically, the client may be asked, "What is good about not thinking of that memory?" Or, "When you realize we could use this session to talk about what occurred when you were a child, how much, right now, zero to 10, do you not want to? How much would you rather think about something else?" Many clients have the attitude, "I don't want to think of it. But I *want to* want to think of it." Of course, if a client truly does not wish to access traumatic material, this method is inappropriate, but generally this is not the case. The more typical picture is one of a strong motivation to address and resolve the disturbance, and the avoidance impulse is experienced as a frustrating barrier to that resolution. In these types of situations, when avoidance is targeted, the typical result is that the defensive process weakens, and the underlying disturbing traumatic material can then be addressed successfully using standard EMDR procedures.

The following transcript illustrates this approach. Veronica, a fifty-eight-year-old woman in weekly therapy sessions, had benefited from previous EMDR treatment for her phobia of certain foods, and in these sessions she had become increasingly aware of a separate child ego state, while also becoming aware of previously dissociated details of sexual abuse by her father while she was between the ages of one and five. The adult had a strong avoidance impulse regarding this traumatic material, out of fear of being embarrassed and overwhelmed by what the child might tell her about the abuse. The following are verbatim segments from video recordings of three successive therapy sessions.

THERAPIST: Last time we started to talk about what happened with your father. We could go back to that again today.

CLIENT: [*Frowns*] After last time, I don't know what she [the child part] is going to say. I really have this feeling of "I don't want to!" I know it would help, but it just feels like I don't want to.

THERAPIST: Okay, then, just be honest. On a scale of zero to 10, how much do you not want to think of it right now?

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How strong is that urge or impulse to just think of anything else?

CLIENT: Not how much I don't want to want to but just how much I don't want to. Okay. I don't want to, about a 9.

THERAPIST: Notice where that feeling is, physically, that feeling of "I don't want to."

CLIENT: I don't want to feel yucky. But... I want to get better. And, if that's what I have to do to get better, I'm going to do it.

THERAPIST: So scan through your physical sensations. Where is that 9 of "I don't want to"?

CLIENT: It's kind of a queasiness in here, and my throat.

THERAPIST: Stay with "I don't want to." I'm turning on the sounds. Stay with that. [*Set of alternating sounds for about 10 seconds*] Stay with how much you don't want to go back into it.

CLIENT: But I *do* want to because I want to get better.

THERAPIST: Stay with that. [*Set of alternating sounds*] Now, stop and just take a deep breath. Look around the room. Just be here. Let yourself pause and take a break from all this. Take a rest.

CLIENT: You know, it starts making that little girl inside think she did something wrong when I act like this. [*Set of alternating sounds*]

THERAPIST: Given all that, right now, use the numbers to really look at the issue. How much do you just not want to, right now? The urge might still be there. It's okay if it is, but how much, right now, do you just not want to?

CLIENT: Half and half, about a 5.

THERAPIST: Okay, is that different from when it was a 9?

CLIENT: Yes, because I really want to get through this stuff. I really want to progress. I really want to get better. I really *want* to be able to do the things I've always wanted to do, like eat normally, you know.

THERAPIST: Good. Stay with that. [*Set of alternating sounds*] Do this: Go back and ask yourself the same question

again. Zero to 10, how much do you *not* want to think of it right now? It might be more.

CLIENT: Not want to think about what happened? I'm *thinking* about it!

THERAPIST: Stay with that.

CLIENT: It's just happening.

THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: It's like that little kid's not going to let me shut her up anymore.

THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: I wish I were as brave as my insides. I wish my outsides were as brave. [*Set of alternating sounds*]

THERAPIST: What are you getting now?

CLIENT: Smells, how I don't like smells.

THERAPIST: Stay with that. [*Set of alternating sounds*]

For the next several minutes, Veronica tells specific details of the sexual abuse. Then, after a brief break to rest and return to present orientation, she once again returns to directly observe the child in the trauma situation, and comes to a realization regarding her previous feelings of shame regarding the abuse. This insight, in turn, helps her overcome her avoidance of seeing her childhood self with "loving eyes."

CLIENT: She's not ashamed to talk about it. I don't understand why. I'd think she would be. Oh, it's because *she's* not following *Mom's* rules. She is herself.... All she knows is what happened, and how it made her feel, and she doesn't know the rules yet. So she isn't ashamed.

THERAPIST: Just think of that. Stay with that. [*Set of alternating sounds*]

CLIENT: [*From the child ego state*] I used to feel so scared when he came home.

THERAPIST: Stay with that. [*Set of alternating sounds*]

With her avoidance defense now much reduced, the adult ego state is able to allow the child ego state to speak directly:

CLIENT: [*From the child ego state*] There wasn't anybody there to help me then.

THERAPIST: Stay with

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THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: [*From the child ego state*] And that is why *I* want to talk so much, because there's someone here to help me. For so long it hurt to know all that stuff, and feel so bad about myself. And no one was there to talk to me, and nobody understood me, and nobody understood. [*Set of alternating sounds*]

THERAPIST: I have a question for the adult right now.

CLIENT: What?

THERAPIST: You let her talk today. Was that something you're glad you did?

CLIENT: Glad. I'm glad.

During the next session, one week later, the child tells, and the adult compassionately hears, many more details about the worst parts of the sexual abuse. Toward the end of that session, the following interaction occurs between the therapist and the client's adult self:

CLIENT: I was afraid of him when he smelled like beer.

THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: I'm not afraid of him anymore.

THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: It feels good to not be afraid anymore. I've been afraid a long time.

THERAPIST: How much disturbance do you have right now, zero to 10?

CLIENT: It's a different kind of feeling now. I don't like what happened, I *hate* what happened, but I don't feel so paralyzed by it. It's further away.

THERAPIST: Good. [*Set of alternating sounds*]

CLIENT: Right now, I want to do for my little girl—inside—what my mom was not able to do for me. I comfort... I hold. I feel like going out and buying her a toy! [*Laughs*] That sounds weird, doesn't it? That sounds weird, but I feel like rewarding this inner kid inside of me that was so much braver than I was. Golly! She had a lot of guts.

Toward the end of the next session Veronica showed a new understanding that her trauma was in the past and no longer triggered such strong feelings of fear.

CLIENT: I feel more powerful today.

THERAPIST: That's good. It shows. So, just to check, go back and think of it again. And what do you get now?

CLIENT: I feel, like... it happened. And it's over. Does that make sense?

THERAPIST: It sure does.

CLIENT: It's like, I remember. It's like looking at a picture, but not being in the movie.

THERAPIST: Stay with that. [*Set of alternating sounds*]

CLIENT: I know, I know it happened. I used to *not know* it happened. I know it happened, and I'll always know that. But, I'm not afraid of him anymore. And I want to try to start looking at things I put in my mouth in a different way.

THERAPIST: What have you figured out today, and over the last few weeks?

CLIENT: I think I figured out that it's not too late to be the person that I want to be. And that I've been awfully hard on myself. And I'm going to try not to do that anymore. She is no longer shut away in the little part. It's me. I'm me. She is me.

I call the procedure illustrated above, which helps the client work through avoidance, the Level of Urge to Avoid (LOUA) method. It consists of the following steps:

1. Ask the client a question that accesses the positive affect, relief, or containment that is associated with the avoidance defense: "What is good about not thinking about that?" or "Zero to 10, how much do you not want to think about that, right now?"
2. Ask, "Where do you feel that in your physical sensations?"
3. Initiate sets of bilateral stimulation. When the target is reaccessed, ask, "How much, right now, zero to 10, would you rather not think of it?" Allowing the client to keep the avoidance defense during processing is typically "softer" and less stressful for the client, and in some instances, is the only available point of access to traumatic material.

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ENHANCING PRESENT ORIENTATION

In Mehmet's case, there was only a moderate degree of dissociation between separate ego states, and the amount of negative affect contained in the child ego state was not potentially overwhelming to the adult part. In the case of Veronica, there was initial avoidance of the experience of the child, which then dissipated as that defense was directly targeted, leading to a constructive dialogue between adult and child ego states and therapeutic processing of traumatic information. However, in many other cases—farther out on the dissociative spectrum—this type of adult-child connection has much greater potential for causing out-of-control feelings and extreme emotional vulnerability. If disturbing memory material has been deeply dissociated, the emergence of that material during therapy can potentially overwhelm the client's sense of being safe in the present. The memory can feel more real than the real situation the client is in, and the experience can be one of nontherapeutic retraumatization.

The Back of the Head Scale

Given these considerations, it is important for therapist and client alike to know when the client is drifting into derealization, that is, losing a felt sense of the reality and safety of the present situation. For clients who are potentially dissociative, the degree of orientation to the present situation can be assessed through the use of the Back of the Head Scale (Knipe, 2002). This procedure is introduced to the client during the preparation phase, before any desensitization of trauma is begun. The therapist says, "Think of a line that goes all the way from here [the therapist holds up one index finger about fifteen inches in front of the person's face], running right from my finger, through your face to the back of your head. Let this point on the line [therapist wiggles index finger] mean that you are completely aware of being present here with me in this room, that you can easily listen to what I'm saying, and that you are not at all distracted by any other thoughts. Let the other point on the line, at the back of your head [therapist points] mean that you are so distracted by disturbing thoughts, feelings, or memory pictures that you feel like you are somewhere else. Your eyes may be open, but your thoughts and your awareness are completely focused on another time, place, or experience. At this very moment, show with your finger where you are on this line."

The therapist should check to make sure the client gets this idea. Most clients who have dissociative experience will quickly recognize this procedure as a way of measuring and expressing a familiar aspect of their mental life. The assumption is that the more the person points toward the "most present" endpoint of the line, the safer it is to do trauma

work with eye movements. Clients seem to be able to easily assess the full range of dissociative experiences, pointing to either a place in front of the face, or to a place parallel with the eyes, or to the temple, or to an area further back in the head, according to what they are experiencing. As a rough rule of thumb, I have assumed that it is necessary for the person to point to a position at least three inches in front of their face in order for trauma-focused work to proceed, although this may vary from client to client. Using the BHS throughout a therapy session can be very helpful in ensuring that the client is staying present while reprocessing disturbing memories.

Constant Installation of Present Orientation and Safety (CIPOS)

The CIPOS method (Knipe, 2002; see Figure 6.1) is used in conjunction with the BHS, and basically consists of using eye movements to strengthen or install in the client's awareness a clear subjective sense of being present in the immediate real-life situation of the therapy office. This method may be used in the preparation phase, prior to the desensitization work, or during the actual desensitization of a particular highly disturbing traumatic memory. By constantly strengthening the person's present orientation through eye movements, processing of the memory can proceed more safely; that is, with much less danger of unproductive, dissociated reliving of the traumatic event. The CIPOS steps are as follows:

Step 1. Obtain full permission from the client to work on the highly disturbing memory in a gradual and safe way, with ample time in the therapy session to complete the work regardless of whatever unexpected traumatic material may emerge during processing. With clients who have dissociated ego states, it is necessary to also ask for and obtain permission from "any other parts that are involved in this memory."

Step 2. Ensure that the client is aware of the objective reality of the present situation in the therapist's office, including the safety of that place. If the client seems unsure of the physical safety of the present situation, this issue should be addressed directly. Sometimes it is necessary, through observations, questions, and discussion, to help the client see that the fears that are being experienced in the present actually are the direct result of a past event, one that ended long ago and often took place far away. This cognitive orientation to present reality does not have to be accompanied by feelings of safety, but it should be clearly established in the client's intellectual understanding.

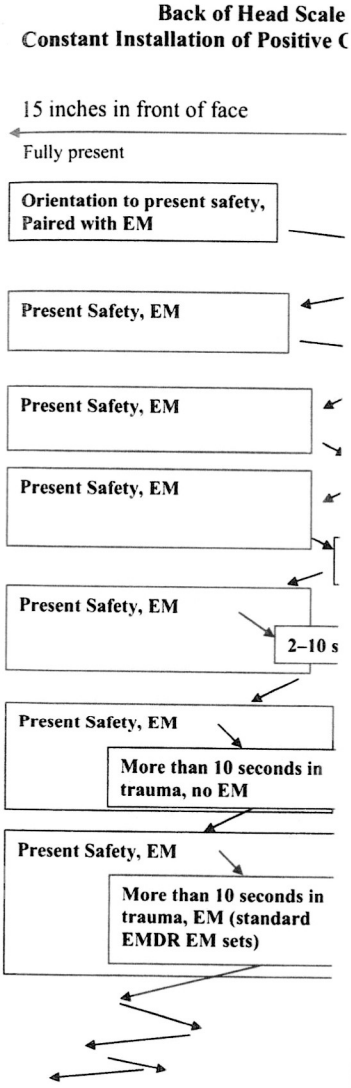

FIGURE 6.1 Flow chart for assessment of dissociation ar the BHS, the client indicates moment, in the session. The between orientation to prese memory. Trauma exposure is movements) and increases g standard pairing of traumati

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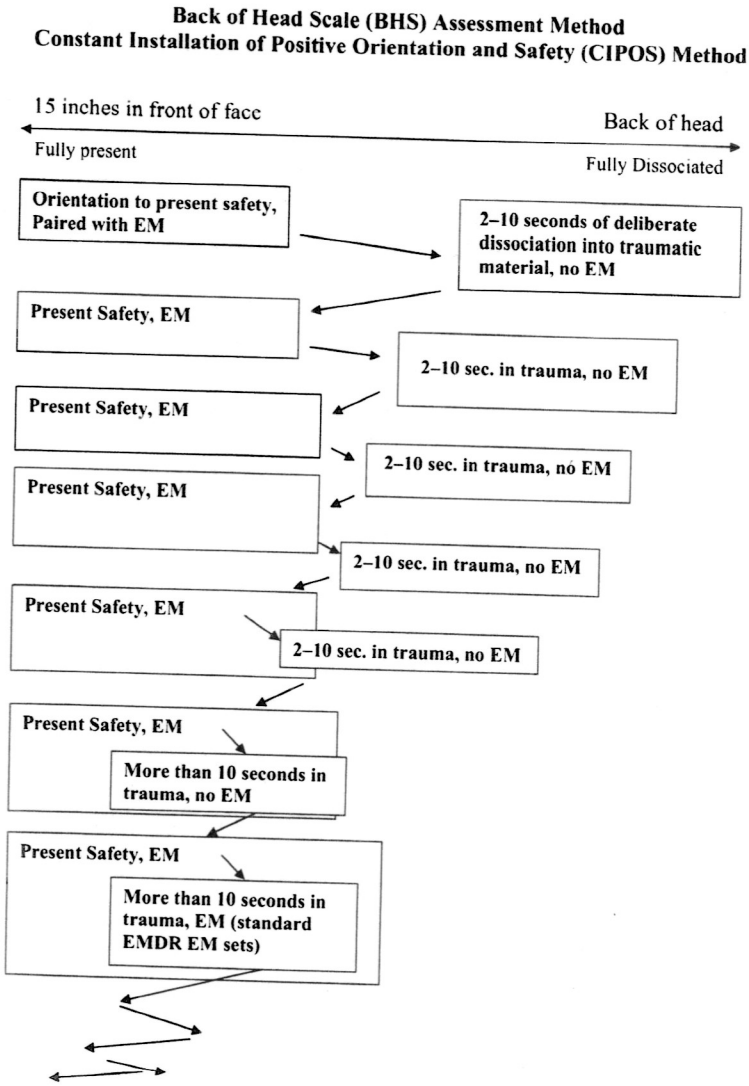

FIGURE 6.1 Flow chart for the BHS and CIPOS methods for assessment of dissociation and grounding in EMDR sessions. With the BHS, the client indicates the degree of dissociation, moment-to-moment, in the session. The session protocol alternates back and forth between orientation to present safety and exposure to the traumatic memory. Trauma exposure is at first very brief (with no paired eye movements) and increases gradually until the client can tolerate standard pairing of traumatic material with eye movement sets.

Step 3. To further strengthen the person's sense of present orientation, the therapist may ask a series of simple questions relating to the client's present reality in the therapist's office, with each client answer followed by a short set of eye movements. Examples include "What do you think of that picture over there?" or "Can you hear the cars going by outside?" or "Can you see the design in this rug?" or "How many tissue boxes do I have in this room?" When the client responds to these "dumb questions," the therapist says, "Think of that," and initiates a short set of eye movements. In addition, the client's subjective sense of being present can then be strengthened by asking, "What's good about being here right now, instead of somewhere else?" Of course, it is much better to be in the relatively safe present than to be reliving a traumatic event, so (usually without much direction) the client is able to say something like, "I'm comfortable here" or "I know I'm safe here," and this positive information can then be strengthened with additional eye movements. If the client is confused about why the therapist is asking these simple questions, the purpose can be explained—a firm grounding in present reality is an essential precondition for the use of EMDR to resolve old disturbing memories.

One particularly useful method of assisting the client in orienting to present time is to engage in a game of catch with a pillow or a tissue. It seems that it is just about impossible to be dissociated from present reality while tossing an object back and forth. Playing catch is an easily performed task, and seems to require the individual to neurologically activate the orienting response in order to follow the trajectory of the tossed object. This procedure seems to reciprocally inhibit (Wolpe, 1958) the activation of excessive traumatic material, which in turn allows the client to be more aware of the actual safety of the therapist's office.

Thus, with the simple questions, the therapist is directly guiding the client to an awareness of these present stimuli, which automatically carry with them feelings of relief and safety.

Step 4. Through the use of the BHS, the therapist is able to assess the effectiveness of the CIPOS interventions. In this way, it can be ensured that the client is remaining sufficiently grounded in the present, so that reprocessing of the trauma can occur. Children growing up near water sometimes receive some wise advice: "Don't jump into water if you don't know how deep it is." If a client wades into an old memory, without one foot on solid ground, it is likely to be retraumatizing, not therapeutic. The BHS is a way of making sure the client remains safely in shallow water.

Step 5. When present orientatic client is willing to go ir period of time (two to t track of the time. This sociative process. Imme of seconds, the therapist repetitive and emphatic now, okay, now come b way back here now. Tha until the client's eyes op room again.

Step 6. At this point, the thera "good," or "that's right. tions with questions lik *fact*?" with the answers The CIPOS intervention report, using the BHS, the therapist's office. At

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CHRIS: DISSOCIAT RESULTING FROM C

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Step 5. When present orientation is sufficiently established, ask if the client is willing to go into the memory image for a very brief period of time (two to ten seconds), with the therapist keeping track of the time. This is essentially a carefully controlled dissociative process. Immediately following the end of this period of seconds, the therapist instructs the client, using soothing but repetitive and emphatic words, to "Come back into the room now, okay, now come back here. Just open your eyes, find your way back here now. That's right. Just open your eyes," and so on until the client's eyes open and the client is looking out into the room again.

Step 6. At this point, the therapist gives words of encouragement like "good," or "that's right," and then resumes the CIPOS interventions with questions like, "Where are you right now, *in actual fact?*" with the answers followed by short sets of eye movements. The CIPOS interventions are continued until the client is able to report, using the BHS, orientation toward the present reality of the therapist's office. At this point, Step 5 can be repeated.

Step 7. As this process continues, the client develops increasing ability to stay present as well as greater confidence and a sense of emotional control in confronting the disturbing memory. This opens the door to the use of the standard EMDR desensitization procedures, that is, directly pairing bilateral stimulation with traumatic material.

CHRIS: DISSOCIATIVE IDENTITY DISORDER RESULTING FROM CHILDHOOD SEXUAL ABUSE

In the following case example, the Loving Eyes method is combined with the CIPOS procedure to contain potentially overwhelming unresolved affect in order to assist a fifty-four-year-old man in resolving a very early and severe childhood trauma. Although Chris has had various diagnoses in connection with past treatment episodes, his *DSM–IV* diagnosis since 1992 has been dissociative identity disorder (DID). I started seeing Chris in therapy in February 1999. At that point he had been receiving mental health services intermittently for twelve years. He was receiving social security disability income for his emotional disorder. His treatment within the mental health system had been successful in that he was no longer at risk for hospitalization, and he was no longer imminently suicidal. However, his waking hours were filled with free-floating anxiety, and, as he would express it, he continued to be frequently "dis-suicidal"—his invented word that allowed him to talk about self-destructive ideation

while avoiding rehospitalization. In spite of this ideation, his actual suicide risk appeared to be low throughout the time of therapy, which has now concluded successfully.

Chris's case was complex, and the following excerpt from a session does not describe this complexity in full. Instead, the purpose of this transcript is to illustrate the use of the CIPOS and BHS methods, in the EMDR treatment of an individual highly susceptible to dissociation.

Preparation Prior to This Session

At the time of this session, Chris had been in therapy with me for sixteen months. The first six to eight months of our work were spent developing ego-strengthening resources (Kiessling, 2003; Leeds, 2002), helping Chris become generally more comfortable in therapy with me, and putting together, as much as we could, a narrative history of his life experience as well as several maps of the internal structure of his dissociated parts.

This work was guided by established methods of providing treatment to individuals with DID (Kluft & Fine, 1993; Putnam, 1989). Within this model, there are basically three stages to treatment: stabilization, trauma resolution, and integration. Chris had actually been able to attain a relatively high level of stability in his life—he owned his own house, had a circle of friends, and was not engaged in substance abuse or self-injurious behavior. With regard to past trauma, he was able to report, in a kind of dreamy, dissociated way, that sexual abuse had begun at an early age. The clearest of these memories were from ages four to ten and involved violent sexual encounters with adult males in the neighborhood where he grew up. He said, "I try not to remember that, but some of the little ones remember it all, and it still bothers them a lot." He reported that he had been aware for many years of the different parts within his personality system.

Our initial use of EMDR with disturbing material was done very cautiously, with clearly visualized, present-day, low-SUD targets such as not wanting to clean up his kitchen and frustration about not being able to drive his car on a snowy day. We also worked on several more disturbing targets from childhood, for example, a clearly remembered incident of being frightened by a drunken man encountered on the way home from school. For the sake of increased emotional containment and control, we initially used the EMD procedure (Shapiro, 1989), which is different from EMDR in that the client is asked to return to the initial visual image after every set of eye movements. In these sessions, we began using the CIPOS and BHS methods, and Chris reported that this work was very helpful to him.

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Difficulties with Self-Assertion and Their Origin

Chris's previous successful sessions became resources as we began to address targets that held more disturbance. In particular, as we began working on a present-day problem, we found that this problem had its origins in an incident of violent childhood sexual abuse. As is often the case with a person with a severe history of traumatization, Chris had considerable difficulty with self-assertion. He reported that it was often terrifying for him to say "no" to another person, especially if that person was in a position of power or authority. This of course was a significant issue, because the ability to say "no" is often crucial in establishing appropriate interpersonal boundaries.

Initially, several sessions of therapy were focused on the ways that this injunction was manifested between Chris and myself. In these sessions we focused through discussion on transference issues and the importance of truth telling in our sessions, with the outcome that Chris was able to express his real feelings much more easily and give priority to accurately reporting his inner experience. This shift, from adaptation to truth-focused therapeutic alliance, was an essential precondition that had to be in place before we could use EMDR with the highly disturbing core memories that remained unresolved.

As we were discussing this issue, Chris told me of several current troubling situations with other people in which this inability to say no was a major problem. We worked with one of these specific situations with EMDR, using the Dissociative Table Technique (Fraser, 1991), with the result that Chris's VOC rating rose from a 2 to a 4 for the positive cognition "I am easily able to say 'no' in a way I feel good about." He felt an increase in confidence following this work, but he also stated that he was aware that this issue remained highly disturbing "to all the little ones."

On the evening prior to our next session, Chris called me to say he had had a very disturbing dream that he was sure was actually a memory of a real event. He was able to contain the affect of the memory dream by making a drawing of it, and the next day in our session he described his drawing in the following way:

> I think I was about four or five years old when this happened. I was walking down by the river in a place where there was tall grass. Some men—they were kind of like bums—jumped out and grabbed me and told me they wanted me to do some things. They took me over to the top of the cliff going down to the river. They put me in a big oil barrel, and they put the lid on it, and then they told me they were going to throw it over the cliff. Here's the drawing I made last night after we talked. When I had the dream, I got these pictures in my mind and these feelings that I'm about to die... or I really wish I would die.

Chris went on to say that this thought was just an impulse, not an actual suicidal danger, but it was nevertheless clear that he was experiencing intense emotion in connection with this memory material. This incident was one that he had alluded to in a previous session, but it was clear now that previously blocked-off visual imagery and affect had broken through his protective dissociation, leaving him vulnerable to an intense reliving of the original event.

Preparing to Work through the Traumatic Memory

In view of Chris's distress in the current session and his success with previous EMDR experiences, we proceeded, with his permission, to make this memory the focus of this session. In this transcript, Chris refers to Little Terri, the dissociated child ego state that holds the unresolved traumatic memory—"the child it happened to."

THERAPIST: [*Looking at the drawing*] So, this is Little Terri, with all the awful feelings on this side of his head.

CLIENT: Yeah, his head split, his mind split from fear, fear and terror.

THERAPIST: And these are the men?

CLIENT: Three of them.

THERAPIST: [*Reading words on the drawing*] "We will kill you if you don't do what we want." "I'm so scared—scared to death. Help, help, help—Jesus!"

CLIENT: He's praying to Jesus.

THERAPIST: "I will always do whatever you want." It's like Little Terri made a promise to them but it was almost like a decision in his life about how he had to be, how he had to live in the world. So, you drew this last night. Chris, let's use our time today—if you think it's a good idea, and if Little Terri thinks it's a good idea—to see what we can do to free him from where he is. I want to be sure, before we begin that though.... Now, how are we going to be sure?—because he'll agree to anything. Does he know that we really want to know if it's okay with him? He does have a right with you and me to say "no" if it's too scary for him to let us try to save him from this place.

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CLIENT: Yeah. From what I've experienced the last few days, I don't think it's Little Terri's fear of exploring it so much as... mine. I got this from flashbacks, years back, and one time recently—I don't know if it was a year ago or something—it flashed back again and I had the awesome terror and panic and fright. In the flashback, the barrel was there, and they took him and there was a big cliff. When he looked down, it was just frightening, it was so far down.

THERAPIST: So, you, Chris, have more fear about this than even Little Terri does. Is that what you're saying?

CHRIS: I think so. When I felt that last night, it was just overwhelming... fear and panic. The greatest fear and panic. Well, they told him, they threatened him, they were going to kill him, 'cause apparently he wasn't doing exactly what they wanted, or something. They had a lid for that barrel and put it on. And it was total blackness in there. And, last night, when *I* got the feelings... it was just unbelievable, I probably wept for an hour, hard, and felt the fear and panic and it was awful, it was just terrible. So frightening, so frightening to have the lid put on. I think children somehow are aware of what death is. And to be scared to death, even for a child, is just traumatic and totally freak-out frightening.

THERAPIST: It had to be way, way beyond your ability as a child, when you were a child, to contain it, to understand it. It probably was so overwhelming that all you could do is just what you did.

I used a distancing interweave to help Chris achieve a greater sense of present-day safety:

THERAPIST: Chris, here's something to think about. We're talking about this today, in a room, just about two thousand miles away from where this happened, and just about fifty years, far away from when it happened. And I'm saying this so that you'll include that information in what you're experiencing right now, not to invalidate your feelings, because your feelings are so strong when you think of this, but to give you a perspective that the source of the feelings

that you are having right now, at this moment—and this is rather strange when you think about it—is something that happened two thousand miles and nearly fifty years away. And there's that distance which actually creates a lot of real safety for you. Now, that won't make the feelings go away in itself. It's just a perspective to have.

I made sure to obtain permission from the system to work on the memory:

THERAPIST: Is it okay with you, Chris, the grown-up, if we work with this today, and see if we can do something to help it feel better? Along the way it might be very frightening, but the end result would be, I think, that it would feel better.

CLIENT: I think that would be good.

THERAPIST: So you the grown-up say that it's okay to work with this? And does Little Terri say that it's okay?

CLIENT: Yeah.

THERAPIST: Now, check inside and see if it's okay with the other little parts that we work with this today. They don't have to be part of it; if it's too frightening for them they don't have to be part of it. What I'm asking is, are they okay with allowing you and Little Terri to work with this today to see if something good can happen?

CLIENT: They say, "Okay."

I now used CIPOS interventions to make sure that Chris was clearly present in the setting of my office:

THERAPIST: Good. Now before we begin to work on this memory, let me ask you some of my dumb questions. Look around and just say where you are. Where are you right now, in actual fact?

CLIENT: I'm here in your office.

THERAPIST: That's right. Think of that. [*Set of eye movements*] And notice what's good about being here instead of somewhere else. Notice whatever the answer is right now, today, when you think of that. What's good

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CLIENT: I like being here.

THERAPIST: That's right. Okay.

At this point, Chris closed his eyes and appeared to be beginning to dissociate into the memory experience, in a way that risked upsetting the therapeutic balance between past and present. In order to help him shift back to the present, I use an additional CIPOS method.

THERAPIST: Now open your eyes again if you can, because that helps you stay grounded here. [*Chris opens his eyes.*] But now notice the pull of the memories; they want you to notice them. So let them know, we'll get to you in a minute, we won't forget you. But before we go there, here is another question: Can you catch a pillow with one hand?

CLIENT: I don't know if I can catch with one hand.

THERAPIST: Try and see if you can. Catch this pillow. [*Gently tosses a small pillow.*] Good. Okay, now, can you throw it with one hand? Now see if you can catch it again. Good. [*Chris smiles.*] Are you more back here now? Notice that you are more back here now?

CLIENT: Yes.

THERAPIST: That's good.

Controlled Accessing of the Memory Material

Initially, I ask Chris to think of the memory for only a short interval of a few seconds, without eye movements. Then I ask him to return to being oriented to the therapy room, to acknowledge that he is objectively safe in the present situation, and then we pair this awareness of present safety with eye movements. In this way, Chris is able to continuously strengthen his awareness of safety and maintain the necessary balance in his dual awareness of past and present.

THERAPIST: And now notice when you close your eyes, just let the memory come, let the memory come like it wants to. And let yourself go down into the memory. That's good. And notice how that feels and notice whatever you notice. [*Three-second pause*] Okay,

now, Chris, open your eyes and come back here. We'll go back there in a minute, but right now, open your eyes and come back here. [*Chris opens his eyes.*] Are you in my office right now in actual fact?

CLIENT: I am.

THERAPIST: Okay, just think of that. [*Short set of eye movements*] That's good. That's good. Now when I stop moving my fingers, let yourself go back into the memory again. [*Chris closes his eyes.*] That's good. Just take whatever you get and just be there and realize whatever you realize about it when you're there. Notice whatever you notice when you're there. Okay, now, Chris, come back again. Come back here. [*Chris opens his eyes.*] That's good. Are you here?

CLIENT: Yes.

THERAPIST: Good. So just think of that and watch my fingers again. [*Another set of eye movements*] Just realize you're here and nowhere else. Okay now, when I stop moving my fingers again, just let yourself go back there again. [*Chris closes his eyes.*] Good. And maybe notice even more this time when you go back there again, notice whatever there is for you to simply observe. That's right, okay. Now, Chris, open your eyes again and notice now, when you do this, is it easier to come back?

CLIENT: Yeah.

THERAPIST: Good. Notice that; notice that it's easier to come back now. [*Additional set of eye movements*] That's good. That's right. Okay, now this time when I stop moving my fingers, keep your eyes open so you can just simply be here without the eye movements but just know you're still here. Just keep your eyes open. That's good. What are you noticing right now with your eyes open?

CLIENT: It's hard to keep them open.

THERAPIST: It pulls very strongly, doesn't it? The urge to go back there.

CLIENT: Yeah. Like last time I went in, Terri is not just sitting in that barrel. He's really struggling and struggling

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THERAPIST: Yes, it's understandable that he's feeling a lot of panic. Now, before we go back there again, just return in your mind to the room here. Okay? Just realize you are here, nowhere else than here. You've been here the whole time we've been talking. We're just talking about old stuff, things that happened a long time ago, a long, long time ago. You're really here right now.

CLIENT: Yeah, it's kind of hard. I don't think I fully come out anymore. I kind of stay in it.

Because Chris is indicating some difficulty in maintaining his orientation to the present situation, I assess for the degree of his dissociation using the Back of the Head Scale. He is familiar with the BHS from our work in previous sessions.

THERAPIST: Yeah, that's what can happen when we talk about these things. Show me with your finger: on a line from the back of your head to right out here [*I hold one finger about fifteen inches in front of his face.*], how far out are you?

CLIENT: Maybe in here. [*Points about three inches in front of his face.*] I'm out enough to help but I can't really get away from it.

THERAPIST: It's not necessary to come all the way out for this to work. Just come out enough so you know that in reality you're out here. You are, in fact, here.

CLIENT: I noticed that helps. Kind of like you said, one foot in and one foot out.

THERAPIST: One foot in the present and one foot in the past.

CLIENT: Yeah, I notice that a lot, that it helps. [*Long pause*] It wouldn't be so bad if people just had sex with children... but when they threaten them and terrorize them, then sex is almost a pleasure, you know, compared to that. Big deal, have sex, who cares, just don't kill us.

THERAPIST: Chris, that is exactly the manipulation that they were planning, I think, so that sex with them would look like good news compared with death.

CLIENT: Perps are smart, very smart. They think of everything.

THERAPIST: You know, what we're trying to do here, and I think you can see that it is already happening, is to undo the damage that was caused by that. Can you see that this is already moving in a positive direction?

CLIENT: Yeah, I noticed last week that it helped a very lot, very much.

THERAPIST: Good.

CLIENT: Yeah, but last night the pain and fear was so much that it kept drawing me back in. So, I would go in and find it and then, dwell in it a little bit and then try to talk to the little parts and then try to come back out of it, but, man, I noticed there is so much pain and fear!

THERAPIST: I know there is more than you thought. But do this now: show with your hand, how far out you are right now.

CLIENT: I'm a little farther out. [*He points about eight inches in front of his face.*]

THERAPIST: Good. So what's different from when—I'll show with my hand—you were here [*I point to three inches in front of his face.*] and now you're here [*I point to eight inches in front of his face.*]. What's different?

CLIENT: I am not as . . . I don't feel so much in the back of my brain as I did a few minutes ago.

THERAPIST: [*Initiating slow eye movements*] Think of that. Just notice that difference. That's good.

What does Chris's statement mean, that he doesn't feel so much in the back of his brain? It is not important that I, the therapist, know the exact meaning to him of these words. Rather, it is sufficiently clear that Chris is describing some kind of positive shift in his experience, toward increased orientation to the present, as measured on the BHS. Thus, my response is to simply strengthen this resource with eye movements, with the result that he is further empowered in his confrontation of the trauma memory.

Accessing the Traumatic Mem

As Chris showed increasing ability a state of dissociation, he was no longer so we could process it.

THERAPIST: Good. Now wh yourself go bac close your eyes *his eyes.*], and keep track of th I'm saying just there, you can you want to sa

CLIENT: It hurts a lot. [

THERAPIST: Okay now, Ch again now. [*He* back out. Find some Kleenex.

CLIENT: Thank you.

THERAPIST: Now remembe Keep the eyes you are. Is it b remember it s you rather be?

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Accessing the Traumatic Memory for a Longer Interval

As Chris showed increasing ability to return to present orientation from a state of dissociation, he was now ready to remain with the memory longer so we could process it.

THERAPIST: Good. Now when I stop moving my fingers, let yourself go back into it, whenever you're ready. Just close your eyes whenever you're ready [*Chris closes his eyes.*], and go back in for about ten seconds. I'll keep track of the time. You can still hear everything I'm saying just fine. If you want to talk to me from there, you can and I'll hear you. Is there anything you want to say to me, from there?

CLIENT: It hurts a lot. [*Begins crying*]

THERAPIST: Okay now, Chris, open your eyes and come back out again now. [*He opens his eyes.*] Come all the way back out. Find the way back out. Be here. Here's some Kleenex.

CLIENT: Thank you.

THERAPIST: Now remember, keep the eyes open. That helps a lot. Keep the eyes open because then you know where you are. Is it better to be here or there? You want to remember it so you can resolve it, but where would you rather be? Which place would you rather be?

CLIENT: I think I'd really rather be here, but I'm more drawn there. Some days in the past I would be drawn in all day long. I used to go inward and stay there.

THERAPIST: Yes, and when you go all the way in and stay there, it tends to not be therapeutic; it doesn't heal. It's like reliving it. What we're doing here is therapeutic because you're going back and forth, and back and forth. It's a world of difference between that and going completely into it, and being much more there than here. Can you see that?

CLIENT: I kind of caught onto that last week.

THERAPIST: That's good. As we continue this, you're likely to get better and better at staying here at the same moment you go there, almost like a split screen in your mind. Just see if that's possible for you now. Just try it out right now and see.

CLIENT: Yeah, it is.

THERAPIST: Now when you're ready, just go back into it. What do you get now when you think of it?

CLIENT: Fear and pain inside us. Panic and nausea. [*Begins to close his eyes*]

At this point, Chris is feeling a strong sense of being pulled into the memory, and so I begin to talk more actively as a way to maintain his connection with me and the safety of my office.

THERAPIST: Now, keep your eyes open; keep your eyes open. [*Chris opens his eyes.*] Take a good deep breath and look around at the sunshine shining on the carpet here in my office... and see out the window... and just do whatever you need to do to really remind yourself that you're here; you're not there. You're really here. You're in a place where you are safe. You're just remembering things. That's all these are; they're just memories. They feel like relivings, but they're just experiences that are stored in your mind in kind of an unfinished way. That's all they are. They're stored in your neurology, somehow. And we're just working it all out so you can be free of these old memories, from all the disturbance of them. You'll still remember what happened; it just won't tear you up anymore.

CLIENT: Yeah, the mental and physical disturbance, that is horrible, because it keeps us stirred up all the time, and the fear and anxiety we feel, just nausea in our stomach... mental disturbance in our brain... that draws us there and draws us there... to the fear, being very afraid of things. [*Closes his eyes*]

Chris appears to be more able now to access a sense of present orientation and safety, so in order to help him recognize this positive change, I ask the following question:

THERAPIST: Right now, this may be a hard question but, how much are you drawn to be there right now, zero to 10, with 10 the most?

CLIENT: Right now about 5.

THERAPIST: Okay, what w

CLIENT: Probably 10.

THERAPIST: Is something
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CLIENT: Yeah, it is.

THERAPIST: Good, think

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about 5.

THERAPIST: Okay, what was it before?

CLIENT: Probably 10.

THERAPIST: Is something changing? Open your eyes again and notice how easy it is to come back. [*Chris opens his eyes.*] Is that a relief to you?

CLIENT: Yeah, it is.

THERAPIST: Good, think of that. [*Another set of eye movements*]

With his increased ability to come out of the dissociated trauma ego state, Chris is now more able to go back into the memory in a way that is therapeutic. He is learning that he is bigger than this memory.

THERAPIST: Okay, in a few moments, I'm going to stop moving my fingers, so be ready now to go back into it, give into being drawn into it again. [*Chris closes his eyes again.*] There you go. Just let yourself be drawn into it. Kind of satisfy that part of you that wants to just go back and think of it again.... That's good.

CLIENT: God, we've got to get out of that barrel. I've got to get Little Terri out of there.

Chris now has a greater awareness of his adult self as experientially separate from his Little Terri ego state. In order to increase the healing connection between these present and past ego states, I ask him the following question:

THERAPIST: Can Little Terri tell that we know about him and that we're trying to save him? Can he tell that's happening?

CLIENT: He does.

THERAPIST: Okay. Now, how does he feel about us trying to save him?

CLIENT: He hopes we will.

THERAPIST: Okay, that's good. Does that help him just a little bit, to know that we are on our way, trying to save him?

CLIENT: It helps even knowing that we know he's in there. He's all alone.

Loving Eyes Intervention

To further enhance the healing connection, I suggest that Chris see his childhood self with eyes of acceptance.

THERAPIST: Chris, can you look right at Little Terri right now and see him in there? Even though he's totally in darkness, you can see him in there, can't you? [*Chris nods.*] Look into his feelings. See into his feelings. Can you see into his feelings? [*Chris nods.*] Stay with that and watch my fingers because this will help a lot. [*Set of eye movements*] Just see whatever you see when you look at him right now and see how scared he is, right after the lid has gone on the barrel. Stay with that.

CLIENT: Let me out! Let me out!

Chris's tone of voice suggests that he is mirroring the words he sees in Little Terri, not dissociating into becoming Little Terri. Nevertheless, to keep the process emotionally safe, I ask him to come back to a clear awareness of present reality.

THERAPIST: Open your eyes now. Open your eyes. [*Chris slowly opens his eyes.*] We'll get back to Little Terri in a minute, but right now come back out of it again. Come back out of it, coming back now. Keep your eyes open; that helps. Just be here. Look around. It's hard to stay here, I know. Isn't it interesting, when you come back here to the safety of this room, how strong the pull is? [*Chris nods.*] Okay, when you're ready, close your eyes and just be drawn into it again. [*Chris nods.*] Let yourself be sure to stay partly here. Little Terri needs so much to know that there are some adults that are on the way. Do you see how that's connected to the pull of being drawn back into it? Little Terri has always needed that. He's always needed to have an adult who sees him with acceptance, who wants to help him be safe, who can know what he's going through. So there's a pull. He needs for us to come back and help him. But before we can do that, it's important to be aware of being safe and being here. So open your eyes now. Is this room a safe room?

CLIENT: Yes, it is.

THERAPIST: Just think of *movements*] room. That's to go into it *open.*] Okay, to keep movi just close you you get wher

CLIENT: I don't go ba

THERAPIST: Just notice th into it now?

CLIENT: It's kind of w Little Terri's

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CLIENT: He actually

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CLIENT: Little Terri and swingir out.

Shift to Standard EMDR D

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fe and being here. So open your eyes now.
n a safe room?

CLIENT: Yes, it is.

THERAPIST: Just think of that, Chris. [*Another set of eye movements*] I'm really glad you know it's a safe room. That's good. That's right. Now, are you ready to go into it again? [*Chris nods and his eyes stay open.*] Okay, let yourself go back into it. I'm going to keep moving my fingers and when you're ready, just close your eyes and go back into it. What do you get when you go back into it right now?

CLIENT: I don't go back in as far.

THERAPIST: Just notice that. What's different when you go back into it now?

CLIENT: It's kind of weird. I feel actually kind of calm, like Little Terri's going to be okay.

THERAPIST: How's he feeling right now?

CLIENT: He actually feels a little better, but he's scared.

[Note the differentiation in affect between the two ego states. Chris, the adult, is calm, while Terri is "better, but scared."]

THERAPIST: Sure he is. I wonder if what you're experiencing right now, Chris, is something that's a little bit surprising for you. Just notice how that is. Go back into it again now. Close your eyes. What do you get when you go back into it now?

CLIENT: Little Terri wants out. He's screaming and kicking and swinging and praying. Please, please, let me out.

Shift to Standard EMDR Desensitization/Reprocessing

At this point, Chris has sufficient orientation to present reality and safety to use the standard EMDR desensitization procedures, that is, to combine eye movements directly with disturbing material from this memory.

THERAPIST: Okay, open your eyes and think of that. [*Eye movements resume and continue while Chris and I are speaking.*] And notice how much fear he has in his body.

CLIENT: It's terrifying.

THERAPIST: Just notice that when he's screaming and kicking. Notice all the fear he has. Where does he have that fear, in his body? Where is that fear located in his body?

CLIENT: In his stomach. His mind is shattered.

The word "shattered" implies an irreversible degree of damage to Little Terri's mind. However, in this context, I suspect this word is being used differently, to simply express the intensity of unprocessed disturbance. Therefore, we focus on the experience associated with this word. I ask Chris to be aware, with acceptance, of Little Terri's shattered mind, and he is able to continue the processing. Also, an informational interweave is added—the idea that the shattering of Little Terri's mind may be reversible.

THERAPIST: Notice how it feels for him when his mind is shattered, how awful that is for him. Just notice that because—you know what?—when you notice how it is for him when his mind is shattered, that begins to heal his mind.

CLIENT: Childhood fear and panic is so awful.

THERAPIST: Yes. So notice how his mind is shattered again now; just notice that. See what happens when you direct your attention to how his mind is shattered. Notice what happens with his mind when he knows that you're seeing that, and you are paying attention to that, and you care about him. Notice what happens. What would you say happens in his shattered mind when he notices that?

CLIENT: It helps him, even though the fear and panic is so great that his mind is just messed up and gone.

THERAPIST: Okay, now keep your eyes open. Stay here, and just notice how disturbing it is for you now. How disturbing is it for you now when you think of it, zero to 10? That's it, go into it and just check it out. How disturbing is it?

CLIENT: It feels quite a bit less. I feel better.

Little Terri's Rescue

The emotion associated with this memory is significantly less than when we started. There is a healing process under way that is proceeding at its

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this memory is significantly less than when
process under way that is proceeding at its

own pace and with its own direction. In order to facilitate this process, I remind Chris of our goal at the beginning of the session:

THERAPIST: Chris, just notice that difference. Remember when we started today, the goal was to rescue Little Terri from that barrel. Do you see that that's what we are doing?

CLIENT: I need to get him out.

THERAPIST: How can we get him out of there?

CLIENT: I think a great big adult, like Jesus, that has powers, could come and take that lid off and pull him out of there.

Taking Chris's lead, I add to his imagery.

THERAPIST: Is it okay if you and I and Jesus come right now?

CLIENT: That would be great.

THERAPIST: Let's do that. Just let that happen now. You, I, and Jesus are here. And notice the three perpetrators; notice how they are when they see Jesus.

CLIENT: They fall on the ground and can't move.

THERAPIST: So what do we do now? Let's go ahead and do whatever needs to be done now.

Chris always brought a backpack to our sessions. He hands it to me.

CLIENT: If this were Little Terri, could you reach in and pull him out? [*He cries.*]

THERAPIST: Yeah, here he is. [*Handing back the backpack*] Here, you hold him, okay? You hold him tight. And while you hold him, just move your eyes now and enjoy holding him tight. That's right. Is it okay if he cries? It's okay, isn't it? It's okay if he cries and cries. He probably needs to cry and cry a lot. You won't get mad at him for crying, will you? [*Chris shakes his head "no."*] That's right. [*Set of eye movements*] I'm going to stop moving my fingers in just a moment. Let yourself go back into it again.

Rechecking the Work

Even though the memory has now been largely processed, I ask Chris to go back to it to see what disturbance may remain and to enhance the positive associations he is making.

THERAPIST: Go all the way back into it now. When you go back into it, what do you get now?

CLIENT: I'm so relieved to be out of that barrel. It's like a miracle. I didn't think I'd ever get out. [*Set of eye movements*]

THERAPIST: Now go back into this memory again. What do you get now?

CLIENT: I feel so much relief.

THERAPIST: Notice when you feel that nice feeling of relief in your body, notice where that is. Let yourself breath into it and enjoy it; enjoy that relief. Open your eyes and follow my fingers and just enjoy that relief. Finally. I'm so glad. [*Set of eye movements*]

CLIENT: It feels so good that it's over. [*Chris closes his eyes with relief.*]

THERAPIST: Chris, open your eyes and come back here. Open your eyes and notice how it's different now when you come back here. Remember when you, just an hour ago, went into it and tried to come back out. What's different now?"

CLIENT: I feel kind of *normal*! I feel okay.

THERAPIST: Normal is kind of nice, isn't it?

CLIENT: Yeah, very nice.

Since the scheduled time for the session is winding down, I ask a question to help Chris recognize the shift in his memory, as a way to consolidate what he has gained in this session.

THERAPIST: Let's do this now. Look over across the room and see that picture that you drew. Just remember how scary that was. Look at that now. What do you get?

CLIENT: That was very scary and terrorizing—mind shattering. Fear, panic.... What perps can do to a child's brain and mind is incredibly evil and horrible,

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CLIENT: The lid is off

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but now that Little Terri is out of there,... that picture can be just what it was like at one time.

THERAPIST: Think of that and watch my fingers. And notice any feelings that are still there, anything that's still part of this whole incident. Just notice whatever there is.

CLIENT: There's still fear. That was only like the beginning of the problems, but that was actually the worst part.

THERAPIST: This was the beginning but it was also the worst one. There were others incidents that came later, and on another day, you and I can talk about those other times. Today was a major, major piece of work you've done. Chris, go back again and think of the worst part—when the lid is going on the top of the barrel. What do you get when you think of that? It still may be disturbing to you. Just notice if it is.

CLIENT: That was the worst part. [*Set of eye movements*]

THERAPIST: Just be with that now. Notice whatever you notice about that now.

CLIENT: It's one of the worst things you can do to someone. [*Set of eye movements*]

THERAPIST: When you go back and think of it again. What do you get now?

CLIENT: The lid is off.

That evening, following this session, Chris left a message on my answering machine, saying, "I can't believe this, but since our session, for a few hours tonight, I've still felt normal." In subsequent weeks, he reported with great satisfaction that this particular memory remained resolved. There were other incidents of severe abuse in his history; however, in later sessions, when we were about to work on other difficult memories, he would spontaneously remind himself that "Little Terry is still out of the barrel."

CONCLUSION

The CIPOS method, in combination with the Loving Eyes procedure, seems to be useful not just with clients with DID, but with any clients who are afraid of being overwhelmed by their own posttraumatic affect. With some clients, this method can be a safe and useful preparation for

full desensitization of a highly disturbing memory using the standard EMDR protocol. This procedure seems to significantly increase the accessibility of EMDR to clients who are vulnerable to dissociative abreaction. However, it is very important that such clients be informed that unpleasant affect may emerge, in a controlled way, and that full permission of the ego state system be obtained before proceeding. It is also important that the client have sufficient reality contact. That is, the client must have a factual understanding that the current emotional disturbance is a residue of the past—the original trauma is over, and the present situation is one of objective safety. It is not necessary for this understanding to feel true, but it is important that the client know that it is true, in objective reality.

The reader may have noted that the standard EMDR assessment procedural steps (representative visual image of the traumatic event, negative cognition, positive cognition, VOC score, emotion, SUD score, and associated physical sensations) are either absent or modified in the above transcript. Usually in standard EMDR these steps are important as a means of bringing all experiential elements into the processing. Indeed, with nondissociative clients, processing often begins or is accelerated by the assessment questions. In contrast, clients who are potentially dissociative typically do not need this extra acceleration in accessing dysfunctionally stored affective information (Hartung & Galvin, 2002). For these clients, the main issue is how to slow the process down so they are not overwhelmed by their own posttraumatic emotion. A metaphor (useful for clients I see in Colorado) is of coming down a steep mountain road, where acceleration is not a good idea. The main issue is knowing how to slow down, how to steer, and even how to stop when necessary. One element of the standard assessment steps—the 0 to 10 scale—was used in the session to ask Chris how much he was drawn into the memory material, but the purpose of that question was to assist him in decelerating, that is, consciously recognizing and containing the ongoing pull of his dissociation.

In a later session, Chris and I went back and used standard EMDR procedures to resolve the remaining disturbance connected with this incident. Revisiting the event in this way was important because Chris's initial resolution involved a fantasy, not what really occurred, and it was therefore important to go back to recover, process, and resolve all aspects of the real events.

In general, an underlying assumption of the CIPOS method is that the therapist is alert to any positive shift in the client's experience of the traumatic memory, and is constantly strengthening these shifts as resources through eye movements. For example, at one point in time Chris reported that he was still "way back in my head." At another point,

a few minutes later, he reportec
six inches in front of his nose. "
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a few minutes later, he reported that on the BHS he had shifted to about six inches in front of his nose. The question "What's different now?" focused Chris's awareness on something positive he had just accomplished, and so his response to this question may be regarded as a resource, which then became even stronger and more positive with a short set of eye movements. As another example, a client might say, "I see now how alone I was as a child." These words express a very sad fact of the client's life, but this realization may nevertheless be a positive step in coming to an adult understanding of the childhood events. Therefore, the therapist might then ask, "Is it good you can see that now?" If the client says, "Yes," the therapist can assume that the new information is experienced as helpful and install it as a resource with an additional set of eye movements.

Throughout the CIPOS procedure, the client's answers to the simple orienting questions may reflect the reality of the therapist's office, but may also express information regarding the trauma itself. For example, the therapist may ask, "What do you like about being here right now in this office?" The client may respond, "You aren't hurting me." Such an answer is clearly more about the trauma than about the therapist's office, and when these types of answers are paired with eye movements, desensitization of traumatic material occurs, but in a way that feels softer and safer to the client.

The BHS can also be useful with clients who present in therapy with depressed affect and an emotionally detached interpersonal style. Oftentimes, the depression partially originates in social anxiety and difficulty in engaging in satisfying interpersonal interaction. The BHS gives therapist and client a language to discuss the issue of being comfortably engaged with others. In addition, long-term goals of therapy, and within session positive cognitions, can be defined in the context of the BHS, for example, "Would you like it if you could easily be out here on the line, and easily enjoy talking with other people?"

The effective use of the BHS is based on the assumption that the individual is able to experience some degree of safety in the therapist's office. For most dissociative clients, a sufficient sense of relative present safety can be developed over repeated experiences of being understood and accepted by the therapist. However, for some people with extensive histories of distrust (originating in betrayal of that trust by others), this will not be possible early in therapy. Even if trust in the therapist is established at a later point, the client may still have an abiding sense that subjective safety is an experience that is unattainable. For such clients, all parts of the system live in vigilance and anxiety, even the ego state that has the function of interacting with other people. Some of these clients, after a period of time, can develop a feeling of being *safe enough* to

slowly and cautiously access traumatic material. For other clients, very early preverbal traumatic experiences may be dysfunctionally stored, not as recognizable memories, but as a negative coloration to present perceptions. This type of transferential distortion can take many forms, but is usually evident in the interaction between client and therapist. For example, a child who is repeatedly hurt or frightened in interaction with caregivers during infancy may perceive present relationships as intrinsically unsafe, without having clear memories of the events that set this attitude in motion. Such clients are likely to be confused when the therapist presents the concept of the BHS and talks about how the client is "here in the present safety of this room," and thus for these individuals, the BHS is not likely to be useful until later in the therapy process.

However, these dissociative clients appear to be the exception. To date I have used the BHS procedure with approximately forty to fifty clients. It appeared to be helpful on all but a few occasions. One exception was a situation with a client with DID on a day of particularly high stress. In this instance, the eye movements paired with an awareness of present surroundings increased the client's disturbance, and so the procedure was immediately discontinued and other methods of self-calming and self-control were utilized. With this same client, on less stressful days the procedure has been very helpful. This illustrates a principle worth repeating: with this client population, neither this nor any other procedure is an adequate substitute for appropriate training, experience, and accurate attunement to the client. But, with this important caveat, the BHS and CIPOS interweaves seem to be useful tools in enabling individuals with dissociative conditions to reconnect with their full life experience and view their childhood selves with compassion and "loving eyes."

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