Idealization and Maladaptive Positive Emotion: EMDR Therapy for Women Who Are Ambivalent About Leaving an Abusive Partner

Dolores Mosquera
INTRA-TP Instituto para el estudio del Trauma y los Trastornos de la Personalidad, A Coruña, Spain

Jim Knipe
Longmont, Colorado

After ensuring safety, treatment of victims of intimate partner violence is typically focused on the adverse and traumatizing experiences and related negative emotions. In addition, in many cases, idealization of the perpetrator and maladaptive positive emotion are initial elements that also need to be taken into account. The concept of dysfunctionally stored information described in the adaptive information processing model can be viewed as being broader in nature than maladaptive negative emotions from memories for adverse experiences and can include dysfunctional defenses such as maladaptive positive emotion and idealized life experiences. Self-defeating, dysfunctional, and unrealistic idealization in a relationship can be treated through targeting, with focused sets of bilateral stimulation, specific positive affect memories that are the origin of the distorted idealization. In this way, the client is able to develop adaptive resolution, that is, a more accurate perception of both past events and the present nature of the relationship. This approach to targeting idealization defenses is illustrated with 3 case examples of women who were ambivalent about leaving a highly abusive partner.

Keywords: intimate partner violence; domestic violence; idealization; maladaptive positive emotion

Beginning with the seminal research of Leonore Walker on domestic violence (Walker, 1979), an often-recurring cycle was identified. This pattern is now frequently referenced as intimate partner violence (IPV), which is the leading cause of injury to women, more than car accidents, muggings, and rapes combined (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Tjaden and Thoennes (2000) found that nearly 25% of women surveyed, in the United States during the 1990s, had been sexually or physically assaulted by a current or former spouse, partner, or dating partner at some time in their lifetime.

A frequent additional element to this problem is the inability and/or reluctance of the recipient of violence to leave the relationship or protect herself in other ways. Escape from an abusive relationship often requires overcoming significant obstacles: financial dependence, fear of retaliation by the perpetrator if escape is attempted, lack of confidence in police and judicial processes to provide adequate protection if escape from the situation is attempted (Murray, 2008; Payne & Wermeling, 2009), and so forth. Additional barriers can include intense feelings of self-blame and learned helplessness (Ford, 2009; Royle & Kerr, 2010; Seligman, 1975; Walker, 1979; Williams & Poijula, 2013). A summary of reports from 10 countries indicated that between 55% and 95% of women who had been physically abused by their partners had never contacted nongovernmental organizations, shelters, or the police for help (http://domesticviolencestatistics.org).

Many women are clearly aware that the relationship is potentially dangerous and must come to an end. The primary issue for these individuals is how to leave this relationship while maintaining their own personal safety. Other victims of IPV have a

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somewhat different presenting picture—one of ambivalence regarding whether to stay or go, in spite of repeated violent incidents within the relationship (Murray, 2008). The interventions described in this article are intended to be useful for the second group of clients, those struggling with their own ambivalence regarding a potentially dangerous situation.

Providing Therapy to Women Who Are Ambivalent About Leaving an Abusive Relationship

On the one hand, individuals who have been victimized by repeated and prolonged IPV and who also show this ambivalence may have strong feelings of fear, helpless, anger, and especially an eroded self-esteem. They may, at the start of therapy, be very vulnerable to self-blaming, following many instances of being blamed by their perpetrator. In addition, they may also have received similar messages from concerned and well-meaning friends and family who are aware of the violence: "Why do you stay with him? Don't be so stupid!" As mentioned earlier, there may also be a history of her being reluctant to use available resources because of intense feelings of shame regarding the ongoing situation.

On the other hand, within the pattern of the victimized person returning repeatedly to an abusive relationship, there is often a distorted and overly positive image of the perpetrator (Ford, 2009; Royle & Kerr, 2010; Williams & Poijula, 2013). Consistent with the adaptive information processing (AIP) model (Shapiro, 2001) of eye movement desensitization and reprocessing (EMDR), we have observed that this type of idealization on the part of the victim is often based on memories of isolated "positive moments" that have occurred in the abusive relationship—including those in which the perpetrator apologizes and promises never to do it again, making the victim feel hope that the abuser will change—and minimize persistent threats and episodic violence.

Within the cycle of violence (Walker, 1979), the perpetrator may contribute to this confusion and indecision by alternating between being unpredictably threatening and violent and being the most pleasant and loving and agreeable partner one could imagine. Within Walker's description of this cycle, the perpetrator's agreeable behaviors are often (although not always) manipulative and constitute a deliberate attempt to confuse the victim and perpetuate the dysfunctional relationship, following an incident of IPV.

Clients who present in therapy with this type of ambivalence are often troubled by highly conflictual memory images. On the one hand, there may be images of one or more highly disturbing violent events, and on the other hand, the individual may also have images of very positive moments with the perpetrating partner. The negative and the positive memory images may be dysfunctionally stored, so that when one type of image is accessed, the other type is much less accessible, and vice versa. These conflicting images create confusion, indecision, low self-esteem, and a sense of powerlessness. This internal conflict can be quite intense. Memories of injuries, broken bones, and horrible betrayals of trust are not necessarily as persuasive as one might expect in helping an IPV victim resolve this internal dilemma. It is our experience that the intensity of the idealization defense may be the primary factor in preventing adaptive emotions, thoughts, and behaviors. Our aim is to describe an approach that has been used successfully to treat the type of ongoing ambivalence.

Extreme internal conflict, within the ambivalent client, regarding the relationship, can be illustrated as in Figure 1.

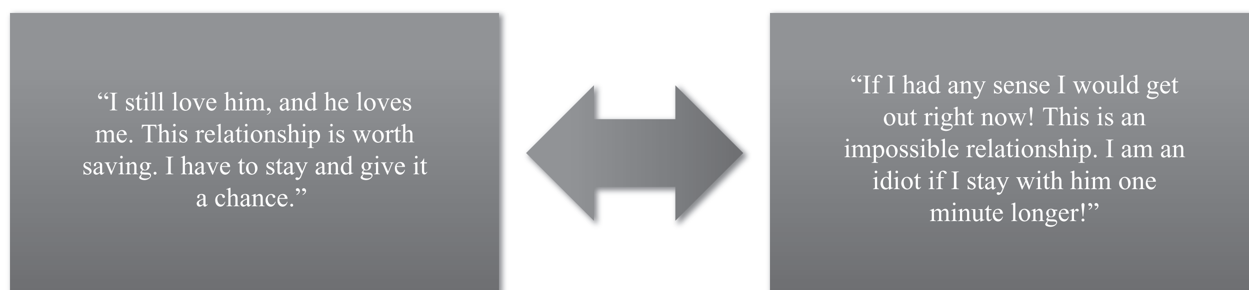

FIGURE 1. The internal conflict or ambivalence that can occur in a victim of intimate partner violence. The two poles of the conflict may be coconscious and simultaneously available in the client's awareness, or they may be partially or fully dissociated from each other, and alternate in the person's conscious awareness.

Thus, for many of the clients who ambivalently remain in an ongoing potentially dangerous relationship, shame about self, along with an unrealistic, overly positive image of the perpetrating partner, are very often elements of the initial clinical presentation (Krug et al., 2002). These are distortions of the actual reality of the situation and may serve the purpose, within the person's mental functioning, of psychologically defending against a full realization of the feelings of helplessness and terror connected with violent incidents. There can be considerable therapeutic benefit in clients becoming aware of and relinquishing this type of idealization defense, and in that way being able to see the situation clearly. However, therapists should also take into account their high vulnerability to self shaming, and know that at times they may need extra reassurance that the therapist is not saying the client was responsible for violence that was in fact perpetrated by the partner. IPV is, of course, directly caused by the violent actions of a perpetrator. Therapists should be very attentive and sensitive to shame defenses, and any existing idealization-of-the-perpetrator defenses, to insure that the client knows the therapist is not "blaming the victim."

Idealization and "Denial Defense"

Early in therapy, idealization and maladaptive positive emotion are often strong contributors to a client's internal conflicts and distress, but these elements are often overlooked if psychotherapy emphasizes the adverse and traumatizing experiences and related negative emotions. We conceptualize idealization, in such instances, as a form of denial defense—one that can block full understanding of the abusive nature of the relationship and, more specifically, block full access to memories of violent and traumatic incidents. In addition, with the distorted idealized perception of the relationship, the client may not develop self-protective behaviors and may be unaware of signs of danger and/or threat, thus becoming vulnerable to repeated exposure to IPV.

Other related distortions often accompany this idealization. Some individuals have learned to associate control and jealousy with love: "My partner does that because he or she loves me so much." Many victims feel guilty when their partner is arrested and/or incarcerated and quickly forget or focus away from the risks and the past violent incidents. They frequently will wish to drop charges and go back to their abusive relationships, if given the opportunity. In this way, idealization and maladaptive positive emotion in IPV situations are serious, potentially life-threatening issues—issues that can be understood and treated within the AIP model.

Dysfunctionally Stored Information and the Adaptive Information Processing Model

The adaptive information processing model (AIP) is the theoretical model for EMDR therapy proposed by Shapiro (2001). It was developed to guide history taking, case conceptualization, treatment planning, intervention, and predict both treatment outcome and the consistency of the many patterns of treatment response. The AIP model regards most psychological pathologies as derived from earlier life experiences that set in motion a continuing pattern of perception, affect, behavior, cognitions, and consequent identity structures. Psychopathology is viewed as resulting from the impact of earlier unresolved traumatic experiences that are held in the nervous system in a maladaptive state-specific form.

The AIP model states that dysfunctionally stored memories are the core phenomena that result in maladaptive coping in the aftermath of incompletely processed disturbing life experiences. When explaining the AIP, Shapiro (2001) states,

> When someone experiences a severe psychological trauma, it appears that an imbalance may occur in the nervous system, caused perhaps by changes in neurotransmitters, adrenaline, and so forth. Due to this imbalance, the information-processing system is unable to function optimally and the information acquired at the time of the event, including images, sounds, affect, and physical sensations, is maintained neurologically in its disturbing state . . . (p. 31)

The broader concept of dysfunctionally stored information (DSI; Gonzalez, Mosquera, Leeds, Knipe, & Solomon, 2012; Leeds, 2016; Leeds & Mosquera, 2015) can be viewed as encompassing more than memories of specific adverse experiences. DSI for traumatic memories is, of course, a core element of the initial clinical presentation of a client with any unresolved memory, and more so of clients who present severe symptomatology associated with personality disorders, dissociation, posttraumatic stress disorder (PTSD), or complex PTSD, among others. However, there are also other kinds of DSI elements involved with the development and maintenance of complex psychopathology. If we narrow the concept of "dysfunctionally stored information" to only include representations of traumatic experiences, we are limiting both our theoretical conceptualization of AIP

and, also, potentially, limiting the use of EMDR procedures to clearly identified memories of traumatic events. Such a restrictive understanding of AIP may unnecessarily extend EMDR Phase 2 (preparation phase) and also unnecessarily limit the many ways that EMDR therapy can be used to target and resolve DSI such as defenses and dissociative separation between personality parts.

To extend the possibility of intervention with specific EMDR procedures, we need to think from a broad conceptualization of the experiential "information" which is dysfunctionally stored (Gonzalez et al., 2012). According to Shapiro (2001), dysfunctionally stored memories can be understood to encompass all of their intrinsic components—including perceptions, thoughts, images, somatic aspects, and emotions. Those memories may distort present experience either in the direction of disturbance (i.e., feeling intense anxiety while thinking of a trauma event, even while being in a safe therapy office) or in the direction of distorted positive affect (i.e., feeling relief at successfully avoiding a trauma memory or continuing to see a dangerous perpetrator as a safe partner). There are times when positive affect can be more dysfunctional than adaptive, and in these instances, clients can greatly benefit from reprocessing these seemingly "positive experiences" (Knipe, 1998, 2005, 2010, 2014; Mosquera 2010, 2016; Mosquera & Knipe, 2015; Steele & Mosquera, 2016; Stowasser, 2007).

Dysfunctional Positive Affect Serves as a Psychological Defense

Dysfunctional positive affect such as idealization—an inaccurate and distorted positive image of another person (Knipe, 1998, 2005, 2010; Mosquera & Knipe, 2015)—can often block access to specific traumatic memory material, thus preventing full processing and healing of traumatic memories. For example, successful avoidance of a traumatic memory can be experienced with affect of relief; idealization of a perpetrator can contain distorted and unrealistic positive feeling. In such instances, the posttraumatic material cannot be fully accessed, and therefore cannot be fully resolved through standard EMDR procedures.

When a mental action blocks the emergence of traumatic material, we describe the situation as one of "psychological defense." Keeping "defenses" in mind may be particularly useful for therapists working with EMDR. When the inappropriate positive affect of the defense is targeted with sets of bilateral stimulation (BLS), the result is a weakening of the defense, revealing the unresolved traumatic memories that the defense "covered." These memories, then, are more available for standard EMDR processing. This is similar but not equivalent to the psychoanalytic concept of defense as a not fully conscious mental action that blocks an internal unacceptable impulse (Freud, 1937). In contrast, the blockage, within the AIP definition of defense, prevents contact with posttraumatic disturbance.

Idealization can serve this defensive function, and we are defining idealization defense as a strong emotional investment in a memory of positive experience, which functions within the person's personality to protect the individual from being overwhelmed by the impact of unprocessed, disturbing memories. If imagery representative of the positive idealization can be targeted and resolved, this may then allow access to the underlying, unfinished traumatic "relivings," which then in turn can be processed using standard EMDR procedures.

Codependence

Codependence is defined as a psychological condition in which someone is in an unhappy and unhealthy relationship that involves living with and enabling ongoing dysfunctional behavior in another person A codependent client is often very troubled by ongoing dysfunction in a relationship, and the client's unsuccessful "solution" that is tried again and again is to shame the self while continuing to be invested in maintaining a positive image of the partner—or, more specifically, how the client hopes and wishes the partner to be. This emotional investment in an idealized image of the partner may be driven by memories of a subset of genuinely positive experiences as well as times when meeting the needs of the other resulted in praise or temporary emotional safety. These positive memories may be emotionally satisfying in themselves, and this positive feeling may block and prevent full awareness of other disturbing and traumatic events that have occurred within that relationship, thus impairing the effectiveness of standard EMDR targeting of those events. In other words, in these instances of intense ambivalence, idealization of the perpetrating partner may be serving as a psychological defense, preventing full and comprehensive realization of the abuse as well as full awareness of choices regarding future actions.

Providing EMDR Therapy to Women Who Have Experienced Intimate Partner Violence

Standard EMDR procedures can be quite helpful in treating many individuals who have been

victims of IPV and who may be continuing to experience learned helplessness. Following adequate preparation, the Phase 3 assessment steps can be applied to incidents that represent dysfunction in the relationship—typically memories associated with the various types of violence—with a representative visual image, negative (NC) and positive (PC) cognitions, accompanying feelings and physical sensations, and appropriate baseline measures on the Validity of Cognition (VOC) and Subjective Units of Disturbance (SUD) scales.

We have often found that during the Phase 3 EMDR "set up," it may be useful to also allow the client to express negative cognitions about the perpetrating "other," prior to asking the client for a self-referencing negative cognition. If the client is experiencing a high level of anger at the perpetrator, this brief exploration will allow the anger to be expressed and heard by the therapist, which then will often facilitate the clients' access to unhappy thoughts about self.

During Phase 3, the client may present, for instance, NCs such as "I can't protect myself," or "I can't escape from this situation," or "I can't say what I really feel." Corresponding PCs might be something on the order of "I am able to take steps to fully protect myself," "I am able to escape a dangerous situation and find safety that is reliable," and/or "I am able to easily say what I really feel with complete respect for the human dignity of both myself and the other person." The clear and specific definition of the PC is often very important in these cases, as a way of assisting the client in forming a strong and compelling definition of a positive future.

Another issue that comes up in using the standard protocol with this type of situation is defining the disturbing emotion. Someone who has been hurt within a relationship might name "anger" as the emotion that is connected to a disturbing violent incident. It is often useful to ask the client, "Is that a kind of *helpless* anger? Or, "Is that a kind of *disturbing* anger? Anger can be an empowering feeling and very appropriate. But it sounds like your anger right now is not that kind—it is more a disturbing kind of anger?" Similarly, a client might report "guilt" as the primary emotion associated with a memory of a violent incident. At times, it may be important for the therapist to clarify whether the client believes that they are truly guilty for what occurred, or, if the client is experiencing a strong, nonrational emotion of guilt, even while recognizing that that feeling of guilt is not objectively justified. Anger that is blocked can sometimes be turned toward the self, for "allowing" the violence to happen (even if, in fact, the victim was powerless to prevent the abuse).

With these types of modifications, standard EMDR procedures can often be quite helpful to a client who has been hurt by IPV. The client is likely to come to see both past and present situations with greater objectivity and clarity and go on with greater awareness of their own resources and choices.

For clients who are strongly ambivalent about the partner and the relationship, targeting of idealization may be necessary as a precursor to the use of the early-described standard EMDR procedures. What are the indicators that signal a need to target idealization? The client may be focused on self-shaming statements, or focused on the need to reunite with the partner. The therapist might elicit all elements of Phase 3 but when trying to reprocess in Phase 4, very little movement occurs. In these cases the authors found it useful to target the positive affect pole of the ambivalence. This approach of using focused sets of BLS to target dysfunctional positive affect was first described and pioneered by Popky (1995, 2005). Knipe (2005, 2010) adapted Popky's ideas to target and process positive affect and distorted perception of other people.

Targeting Idealization Defenses With EMDR. An individual might have a cherished positive image of a person, of self, or of an action, and the emotional investment in the positive image—protecting and maintaining that image—may prevent full access to underlying traumatic memories as well as other more realistic information, which may be necessary for adaptive resolution of a particular problem. The level of positive affect (LOPA; Knipe, 1998, 2005, 2010, 2014) procedure is a way to process and resolve this type of dysfunctional positive affect image. The steps in the LOPA procedure are described in Table 1.

Case Examples

For many survivors of IPV coming to therapy, the idealization defense is the only available point of entry into the dysfunctional trauma memory network that is the source of the client's negative feelings. This approach is illustrated in the following examples where positive memory images were targeted with focused sets of BLS, and the strength of the client's idealization defense was significantly diminished. This shift, in turn, allowed the clients to come to an adaptive understanding, with objective clarity, of the dangerous and dysfunctional nature of these relationships.

TABLE 1. Level of Positive Affect Procedure

- Identify a specific memory image that contains positive emotion and represents the distorted idealized affect. The type of memory will differ, depending on the type of idealization. For example, for self-idealization, the client might be asked, "Can you remember a time when it became clear to you that very smart people, like yourself, are sometimes entitled to break the rules? [or '. . . are entitled to control other people']." It is important for the therapist to ask this type of question without suggestion of shaming. Idealization of another person, or of a relationship, can be initiated with questions such as "Is there a 'best moment,' a time you can remember when this relationship was very fulfilling and satisfying? Is there a good feeling connected with that time?" or "Is there a particularly pleasant memory that represents your feeling of love for ________? [or "represents your wish to never let that person go?" or ". . . represents your wish to hang on this relationship?"]."
- If the client is unable to think of a purely positive memory but is able to identify a memory image with both positive and negative affect, the instruction from therapist can be, "I know that when you think of that time, you have mixed feelings, but would you be able to briefly put the negative feelings aside, and simply focus on the positive feelings that still are there when you think of that time?"
- When this "best moment" is identified, the therapist can ask for associated positive conditions—not only positive self referencing cognitions (i.e., "I am loved.") but also other-referencing positive cognitions (i.e., "He gives me safety and protection." or "He loves me in a way that no one else ever has.").
- The intensity of positive feeling associated with this representative memory can then be put on a 0–10 level of positive affect (LOPA; Knipe, 1998, 2005, 2014) scale, and that feeling can be located in physical sensations.
- Then, memory image, positive cognitions and associated sensations can be held in mind while sets of bilateral stimulation (BLS) are initiated.
- As processing continues through repeated sets of BLS, negative affect information may come into the client's awareness, and be processed.
- In spite, although, of this emergence of negative information, it is typically useful to continue to "go back to target" by asking the client to think of the "best moment" repeatedly, and each time report what the LOPA score is, "right now." By emphasizing the words *right now*, the client is assisted in seeing that the positive investment in the idealization is diminishing.
- The typical result of this procedure is a relinquishment of the defense, resulting in a more realistic perception of the issue that is the focus.

Note. Within these procedures, the client is asked to access a particular memory that contains the positive affect of the defense (e.g., the very pleasant emotion associated with distorted idealized imagery) and then the distortion in this memory image is resolved through repeated focused sets of bilateral stimulation bringing the client to "adaptive resolution"—a relinquishment of the defense, resulting in more realistic perception of the issue that is the focus.

Case 1: Bright Sunny Day

This 35-year-old woman was referred to therapy from a program for women victims of violence. Her male partner was in jail for almost killing her during a beating that occurred shortly before her first session. There was a history of many prior incidents of violence that had occurred in this relationship, but the client never reported them and tended to minimize them. She was convinced that he did those things out of love, and she interpreted the violence as her fault—she believed that she had acted in ways that "gave him motives" for his violent behavior.

Client and therapist identified the worst memory: the last beating, a moment where she almost died. The client was able to identify all the Phase 3 elements, but when we began Phase 4, the reprocessing/desensitization phase did not seem to work; she would loop unproductively, crying and speaking, without any movement toward resolution. Her emotion, although intense, was not connected with the reality of the event. She appeared to be only processing at a cognitive level. The client stated that she missed her partner and was thinking about dropping the charges. She also said, "I look better on the outside [no marks on her body, following healing of her bruises] but feel worse on the inside." The client was able to acknowledge that the whole situation remained potentially dangerous, and so she agreed to target her confusing positive feelings about him. The processing began with her talking about her attempts to restore the relationship. The client went to jail to give him his belongings. She says this makes her feel better, "The hope of getting him back keeps me alive. I know that's not good."

Exploring the worst part of being without him.

Not being with him, loneliness. I don't know why, I am much worse than at the beginning. Why is this happening to me? (P.)

The client's ability to process this dilemma appears to be blocked by a dysfunctional positive investment in an image of this boyfriend as a wonderful loving partner. Holding on tightly to this positive image prevented her from having full realization of how this relationship had been repeatedly problematic. Therefore, her strong positive affect regarding her memory of the "best part" seemed to be the main problem.

C: I feel bad for him, because I miss him, but not because of what he did to me. It shouldn't be that way.
T: That's why we will try to diminish the strength of that idealized way of thinking about him. So, try to think of a moment that represents the best experience with him.

The best moment will be the target for processing.

C: I was waiting for him at a park. There was a column, and he was hiding there, looking at me. When I noticed him, he looked at me tilting his head, and smiled, very happy. I don't know. It's a silly thing.
T: It's not a silly thing. Think about this picture, and from 0 to 10 how nice is it?

This is a different use of the 0–10 scale. It is not an SUD scale, but is a scale of LOPA (Knipe, 1998, 2005), a measure of the amount of dysfunctional positive affect the client still has, which is serving as a defense against full access to disturbing traumatic memories.

C: It is a 10. It was a beautiful moment for me.
T: When you think about that memory, what are noticing in your body?
C: A nice sensation, something over here [pointing at her chest, heart area].

Once the representative image of the "best moment" is identified, along with the accompanying body sensations, we begin processing.

T: Okay. Stay with that. [set of BLS]
C: It's his face of happiness, of "I found you!" . . . His face of happiness!
T: Ok, focus on that and allow whatever comes up, to come up.
C: This was calming me. I don't know why.
T: It's okay. Don't worry. Just let things happen naturally.
C: But I am going crazy! [starts to cry]
T: Okay, focus on that. [set of BLS]
C: Now my head is not so focused, I was thinking about the device [client was holding the tappers], the movement from one side to the other.
T: Okay, go back to the memory and notice how nice it seems now from 0 to 10.
C: Okay.
T: Without BLS, think about that, and notice if the intensity is the same.
C: No, I cannot think about it in the same way. I notice . . . like an electric current all over my body.
T: Concentrate on that. [set of BLS]
C: I cannot think about it.

The client's idealization of the partner is weakening, and the client is experiencing some temporary confusion. The therapist explains,

T: That's why we are working on this, so those things that hurt you don't have so much power over you, because you need to think about yourself, about realistic things.
C: I feel less excitement in my body. The memory is exactly the same, the same face. But now I can feel it, it's hurting again . . .
T: Okay, focus on that. Go with that, and let whatever comes up, to come up. [set of BLS]
C: I want to remember. I want to get anxious. But it goes away very fast. I can hardly remember that. Sometimes I cannot, sometimes I can.
T: Go with that, okay? [set of BLS]

The client is now somewhat confused by her lack of anxiety in connection with this relationship. Up until this session, sense of danger was always an element of being with her partner, and now she is developing a more realistic perspective. This is something that often occurs when long-standing defenses are resolved: there is an initial disorientation. It is usually helpful, and sufficient, to simply tell the client that this relative absence of anxiety is the result of their own successful work in their therapy session.

The client then moved on to another "channel" of processing.

C: But . . . what was bothering me, at the end, was to think, "I will never have this again." I am not talking about the memory. It's about not living that situation with him anymore.
T: Ok, focus on that, because this is what is blocking you.

C: It's a sunny afternoon, and he is not there, and this makes me anxious.
T: Go with that. [set of BLS]
C: The thought of "it doesn't matter. I am with my son. It doesn't matter," came to my mind. But that's when I want to go crazy. But at other times, I get the image [the positive memory image] again.
T: Ok, focus on that. [set of BLS]

The client appears to be having an inner conflict between the part of self that still holds some of the dysfunctional positive image, and the part of self that is aware of her ability to live without the partner. With one set of BLS, she is able to resolve this inner conflict.

C: Now I can barely think about that. I was only thinking that he came over to me and said, "Go away."
T: Go with that.

This client still is confused because she had previously thought that she had a very positive loving relationship with this partner. Psychoeducational interweaves are needed to help her sort out this remaining confusion.

C: Why I am like this? Because I can't see what happened as something serious [dangerous]. Is it serious?
T: Think about a person that you love.
C: My son.
T: Try to think about a woman that you love.
C: Yes, my mother.
T: If her partner did the same things that your partner did to you, what would you think?
C: I would think it's extremely serious. But it's not the same with me.

This statement reflects the client's sense of being shameful and undeserving. This type of negative self-assessment is often connected to unrealistic positive idealization of an abusive partner. Up until this session, the client was blaming herself for all the problems (i.e., activating a shame defense) to maintain this valued, although unrealistic, positive perception of the boyfriend.

T: Well, he did a great job making you feel that way. He did a great job . . . making you feel that what he did [the abuse] was not important. They are specialists on doing that, in general. He is not the only one; people with that profile are specialists in making other people responsible for the damage, and trying to make other people feel guilty.
C: Okay.

With continuing focused sets of BLS, the client's AIP now is moving toward "adaptive resolution," tending toward healthy realization and associations to more realistic information.

C: It's funny, because I want to go with him, but at the same time I don't. My mind thinks about me going out alone, without him.
T: Go with that. [set of BLS]
C: I want to go out, but then he starts to cry . . . and I go back to him. I want to go with him and I don't. I want to and I don't!
T: Stay with that. [set of BLS]

Accurate reality perception and adaptive resolution come up in the associative chains.

C: Now what I get is like real . . . I wanted to say "no" to him, tell him to "go away." Before, he would pressure me and I couldn't say "no" to him.
T: Go with that. [set of BLS]
C: Now, I got something that really happened. The day before he hit me so bad, that's what he did. He cried a lot. He asked me not to leave him. But I didn't want to think about that. But the thought came to my mind because I was linking things, relating this to the other images. But I didn't want to think about it. My mind wanted to go blank, and I started to focus on the noise, to avoid thinking about that.

The client is noticing her very strong avoidance response, but she now has some distance from that avoidance urge. The therapist encourages her to continue her processing.

T: It's important for you to think about that. If that is coming to your mind, there is a good reason.
C: [contacting with the memory after idealization and avoiding defenses have decreased] Now I only want to cry!
T: Ok, focus on that . . . let it out. [set of BLS]
C: I don't want to cry!
T: [interweave] Allow yourself to feel it.
C: Now I wanted to hug him, you know, to take care of him as I was crying . . . but I have a doubt. I thought, "Do I really love him? Why am I with him?"
T: Okay, focus on that, allow whatever comes up, to come up, okay? [set of BLS]
C: Now I was seeing like a circle, from the beginning of the session, when I remembered his smile, until

now, when I remembered him beating me. Just like a circle, his smile, his beatings, something like that.

T: Ok, go with that. [set of BLS]

C: Now I only can remember when he is beating me. He is beating me, treating me badly, and so on, and not only that moment, many moments, but only moments when he became crazy, beating me, insulting me . . .

Next session:

T: When you think about the memory [the "best moment," when he smiled at her] that we worked on in our last session, what comes to your mind?

C: I cannot forget that. Since we worked with that, it's always present. When I think about the therapy I always say to myself: "I went from that moment to this moment" [from the positive moment to the memories of the beatings].

T: So, you don't feel it as positive?

C: No, not at all, it is exactly as it was at the end of the last session.

After a year, the changes were maintained. The patient reported that she no longer missed this ex-boyfriend and did not even thought about him very much. She never visited him again and was able to go to court to testify against him without any difficulties or regret. The ex-boyfriend was convicted of assault, and the client experienced an increase in self-esteem, knowing she now was able to fully realize the reality of the situation, and effectively protect herself.

Case 2: Our Moment

At the time of initiating psychotherapy, Barbara was 42 years old. She was stuck in a toxic relationship that had been going on for more than 3 years. She was unable to break up with her partner, or even realize, fully, how he was maltreating her. She only came to therapy when he cheated on her or mistreated her (or her pets).

As with the previous client, Barbara had grown up with many adverse experiences in her family. Throughout the first 6 years of her life, she frequently witnessed her father beating and threatening her mother. Mother finally escaped father's control when father threatened to burn mother and daughter alive. It was at this point that mother filed for divorce. However, these prior experiences were never discussed between Barbara and her mother.

Due in part to this background, this client, as an adult, placed the utmost importance on having a conflict-free relationship with a partner. The client had tried to kill herself several times after arguments with her partner. During her last suicide attempt, she jumped out of a window and broke several bones in her body. She was hospitalized for several months.

When she was still recovering, her partner beat her severely. The neighbors called the police. She did not want to press charges, but when the police saw the severity of her wounds, they arrested the partner. She then obtained a restraining order, and moved in with her parents. But in spite of taking these steps to protect herself, she still reported, in her therapy, that she missed her partner and wanted to get back together with him.

Although the therapist tried to target childhood memories related to maltreatment from father, and witnessing her father beating her mother when she was little, these attempts were unsuccessful. The client would report her thoughts, but there were no changes in the SUD or any emotional connection with these memories. Because of the lack of results with these previous targets, the therapist decided to target a representative idealized moment with this perpetrating ex-boyfriend.

The client mentioned two very good moments: "When we were together on the couch and he would lean on me so I would caress him" and "When we went to the beach and went in the water together."

C: There were very few good moments but those were really nice.

T: Which moment is nicer for you right now?

C: The couch one, it was more frequent and the feeling of closeness is deeper.

As in the previous example, the 0–10 LOPA procedure is used.

T: How nice is that memory from 0 to 10?

C: A 9.

T: What emotions come up when you think about that memory?

C: Nostalgia. Sadness.

Even though the targeted memory is reported to be positive, it defensively covers negative affect. Because this memory is then processed, the positive affect is significantly diminished, and the negative memory material comes more clearly to the surface, where it too can be processed.

T: Where do you notice that in your body?

C: Stomach.

T: Stay with that. [set of BLS]

T: What do you get?

C: It was one of the few moments we were close. He was not affectionate, so it was the only moment where I could touch him and feel him close.

T: Go with that. [BLS]
T: What do you get?
C: [crying] The same sensation.
T: Go with that. [BLS]
T: What do you get?
C: I don't understand how he could go from that moment to the beating. I could never beat anyone like that, and without any reason. I couldn't do that.
T: It's very confusing.
C: Yes.
T: Go with that. [BLS]
T: What do you get?
C: I only wanted to have a normal life. I loved him. I just wanted to be with him and have a normal life. But he wouldn't give up alcohol or drugs, so that wasn't possible. And then he would tell me I didn't do enough to get well, that we would never have kids, and that he was going to find another woman! He's got some nerve! When he was the one that didn't do anything to get himself well!
T: Go with that. [BLS]
C: Deep down I knew it . . . but I didn't want to see it . . . I did see it, but I didn't want to give up.
T: Go with that. [set of BLS]
C: You can't change someone who does not want to change. And you get caught up in their life style . . . Back to target.
T: If you go back to the memory, of being with him on the couch, how nice is it now from 0 to 10?
C: A 7. Maybe I want to believe it's a 7, but it's an 8.
T: It's fine if it is an 8. Go with that. [set of BLS]
T: What do you get now?
C: Disillusion. Disappointment. Sadness.
T: Can you notice that?
C: [Sobbing] Yes. [BLS]
C: I don't know if I will be able to trust another man again.

She connects with the memory of her sister's boyfriend who, at first, seemed to be a very nice guy, but later turned out to be cheating on the sister. The sister's boyfriend was trying to keep both relationships in a very selfish and manipulative way; saying he loved both and would like to keep them both.

Back to target. BLS.

C: Now I see that those moments . . . I made them mine but they were not for me. They were for him. He would get close to me so I would caress him, because he liked that. It was the only moment when I could feel him and touch him, but it was not our moment. It was his moment, and I tried to make it ours. But it wasn't.
T: Go with that. [BLS]
T: What do you get?
C: That I was blind. He didn't love me. Somebody who loves you does not take 15 minutes to see if you are okay after you jump out of a window [referring to what happened right after her severe suicide attempt]. When I was in the hospital I realized how little I meant to him. But it was so painful! It was so painful that I didn't want it to be true. I tried to find an explanation, but there was no explanation. He is selfish. He comes first, and then him, and him again. And I was just somebody who was there to caress him or cook for him.
T: Go with that. [BLS]
C: I get some clarity, the lack of enthusiasm I felt when he got home. I was happy during the day, with the dogs. But as soon as he walked in, this changed. He was always serious. Many times, he wouldn't even say hello to me. And he never slept with me. In 3 years, maybe he slept with me 2 or 3 times. That was not normal. And I thought it was. I thought, "This is how it is. That's it." But I don't have to put up with that. I am better off alone.
T: Ok. Think about that memory now. From 0 to 10 how nice is it now?
C: A 4.
T: Go with that. [BLS]
T: What do you get?
C: His selfishness.

Because the idealization is now processed, the client is able to have full realization of the reality of this relationship—a realization that previously would have been painful—of how this man was not a good partner. She went on to give an example from early in the relationship where he expected her to work, to do everything in the house, while he sat and watched TV. Typically, regarding household tasks and maintenance, he did not work or collaborate in any way. As part of her deeper realization, she said, "I don't understand how I put up with that! I have been a puppet. A rag doll!"

T: Go with that. [BLS]
T: What do you get?
C: I spent 6 months with my family. My grandparents were there too. And that's when I realized what it meant to be loved, what it was like to mean something to someone and to be cared for. I didn't have that with him. But I still couldn't see it when I went back. [BLS]
C: I get the night he hit me. I didn't want to press charges, I didn't want them [the police] to take him away. The cops took him away because they

saw my injuries. They asked me to press charges and I didn't want to. And then I went to trial. He said I was crazy and it was self-defense. That's when I looked at my lawyer and said, "This has to end, no matter how much it hurts. Go ahead, press charges." Not only did he beat the shit out of me. He wanted me to look crazy. What the heck? Back to target.

T: If you go back to that memory now, how nice does it seem?
C: Not at all . . . A 0, or maybe a 1 . . . maybe just a little bit.
T: Can you notice that little bit?
C: Hardly, but yes, a little bit.
T: Okay, even if it's just a little bit, notice it.
C: Okay. [BLS]
C: It was not my moment. It was his.

At the end of the reprocessing, the memory did not feel positive at all. By reprocessing the best moment, she was able to connect with adaptive information and assimilate the reality of what had occurred. When she finally realized that this had been a toxic relationship, she was able to let go. She did not miss him anymore and was able to focus on her self-care. The client was very surprised with the result, and the new realistic vision was maintained in follow-up sessions. Later on, therapist and client were able to target childhood memories with success.

Case 3: Love Letters

A 48-year-old woman was referred from a program for women victims of violence after her partner tried to kill her. She had been in a relationship with him for over 10 years. There were prior beatings, constant humiliations, and demeaning behaviors. None of them were reported. He would write nice notes and letters apologizing for his behavior and expressing how much he loved her. She would experience very positive feelings while reading these notes and letters, and then she would attempt to put all the maltreatment out of her mind. At the time the client came to the first session, the offender had a restraining order and was in prison, waiting for trial. The client felt guilty and said she missed him very much. She reported that she was thinking about him constantly. The worst part of this situation for her was "not knowing if we will be together again" and the anticipation of deep loneliness. Rationally, she understood that he had nearly killed her, but emotionally, she minimized what happened and kept an idealized image of this perpetrator.

This client had grown up in a family that was severely lacking mutual support and loving connections. She alluded to these problems, but when the therapist attempted to explore childhood events in depth, the client said, "No, please! I can't go there. It hurts too much." She was willing to explore and work with her difficulty regarding the perpetrator, and she knew it was related to her childhood, but she did not give permission to discuss the unhappy times within her family, ". . . at least for now." She was able to say, "I know this is all related to my childhood and the lack of love. I always longed to be loved."

Several traumatic memories, including the last beating were targeted, but the reprocessing seemed stuck. She would cry and cry, but no shifts would happen. As with both of the previous cases, the problem seemed to be her very strong positive affect and emotional investment in remembering the "best moments." Two best moments were targeted in this case. The first target was related to the notes he would write apologizing to her for having assaulted her. These were precious moments for her. One particularly powerful positive memory image was a time when she woke up, and found a rose and a note by her bedside. She kept all these notes as treasures. A memory image that represented the "best moment" was the picture of the rose with the note. She had a really nice and warm sensation in her body when she thought about this image. When asked how nice the memory was on a scale form 0 to 10, the client reported it was a 10. Just as in the other cases, the client was able to reprocess the positive emotion related to this defense—this idealized memory—and connect with the reality of how this relationship had been dysfunctional in many ways. She was very surprised with the result. During the following session (EMDR Phase 8, Reevaluation), she said, "I did not think about him like that again." Moreover, she went to trial and was able to look the perpetrator in the eyes. She felt very good when she realized she could hold the eye contact and he was the one who had to look down.

A few months after this session, while she was cleaning up, she found, in a drawer, old love letters from him, from the first years of their relationship. She began to read them, and connected to a memory of the perpetrator telling her how special she was. She began to have a good feeling about him again, even while realizing that this feeling was "not real." She then tried to throw the letters out, but reported she could not bring herself to do that. In describing the situation, the client realized that she was confused and emotionally upset. On the one hand, she now realized that this relationship had been very conflictual and troubled, but on the other hand, she still had a lingering positive image of this former boyfriend. She said, regarding

the letters, "It's all I have left [from him]." In spite of her ambivalence, she agreed to proceed with targeting the picture of letters, letters in which he would tell her how special she was for him. Because this positive affect was targeted with focused sets of BLS, the intensity of the remaining idealization defense diminished, revealing many other negative memories, which were then much more available for successful processing using standard EMDR Phases 3–7.

She connected with many moments of maltreatment, and really came to realize, not only cognitively but also at a feeling level, that the letters had been a way of manipulating her after the beatings, cheatings, and humiliations. After the idealization was processed, she said, "What is hurting me the most is at home [referring to the letters]. I am going to throw them away. I can't believe how little I have thought about myself. There are people around me who really love me and I couldn't see that." When she went home after this session, she was able to easily throw away the letters. She called the therapist later that day and proudly said, "This felt really good. I feel like a big burden has been lifted." At the next session, the client said,

> The work we did with the letters was very helpful. I am taking care of myself and spending time on me. As soon as I got home, I was able to throw the letters away and it felt really good. The other day while cleaning up the house, I found another letter and I threw it away without batting an eyelid. It was great.

Following this successful session, the client was able to more easily access and resolve disturbing memories of childhood loneliness.

Discussion

We all can have nice memories of good times with others, and feelings of liking, caring, and respect for those people. But the examples in the preceding text describe a different type of situation; one in which the idealized image of a perpetrator and its accompanying feelings of positive regard, while pleasant in themselves, serve a defensive purpose and can inhibit clients' awareness of danger and thus prevent them from mobilizing behaviors of self-protection. Idealization can also occur after a dysfunctional relationship has ended and the person continues to hold intense feelings of longing for the partner who is now gone.

We may encounter these same dynamics when an adult client is looking back on childhood abuse situations that were perpetrated by caretaking adults (i.e., a parent, an uncle, a teacher, etc.). Ross (2012) has described this as the "problem of attachment to the perpetrator," a situation in which there is a "locus of control shift"—a strong compelling tendency to blame the self for abuse, while continuing to hold an unrealistic, idealized image of the perpetrator. These situations involving early abuse in families tend to be far more complex, and in a subsequent article, we will discuss ways in which the LOPA method can be used, along with other EMDR-related tools, to safely assist the client in resolving this type of dilemma, and no longer feeling either inappropriate idealization of a perpetrator or inappropriate shame about self.

Idealization defenses may stand in the way of successfully reprocessing posttraumatic images and feelings with standard EMDR procedures and therefore must be taken into account in order for the client to fully and comprehensively resolve their traumatic memories. Identifying and understanding how an unrealistic idealized image can be processed as DSI can be particularly helpful in the case conceptualization of personality disorders and other complex trauma cases. The therapeutic power of the AIP method can thereby be extended to a significantly larger population of clients—those for whom a cherished but unrealistic positive image of another person prevents accurate reality perception, effective self-protection, and comprehensive trauma processing.

The procedures described in this article are designed to provide an effective therapeutic response to this specific clinical issue of client ambivalence arising in the treatment of victims of IPV. Within these procedures, the idealization is targeted and brought to adaptive resolution through focusing on the clients' "best moments" with their perpetrator—memories of which are driving the current inaccurate idealization. When clients' perception of the situation is no longer distorted by the idealization, they are then able to work on and achieve other goals of therapy, such as resolution of disturbing memories, increase in self protection skills, and improve self-esteem. These procedures, targeting idealization, do not constitute a rote "protocol" but are intended to be used flexibly, and in conjunction with the therapist's clinical judgment, for the client's benefit.

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Correspondence regarding this article should be directed to Dolores Mosquera, MA, INTRA-TP, Instituto para el estudio del Trauma y los Trastornos de la Personalidad, General Sanjurjo 111, 5, 15006, A Coruña, Spain. E-mail: doloresmosquera@gmail.com