

# The *I—Gaze Interweave* for Attachment Repair in EMDR Therapy

Barry Litt, MFT  
EMDRIA Approved Consultant

## ABSTRACT

Approximately 40% of the general population suffers from an insecure attachment style from infancy. These individuals are disproportionately represented in the psychotherapy population. Seen as a scalar phenomenon, the presentation of insecure attachment can range from an occult co-morbidity of anxiety and depression to disabling personality disorders, intractable relational dysfunction, and self-harm. The associated symptoms of depersonalization, psychic numbing, and affect dysregulation present serious clinical challenges for which specialized interweaves may be necessary.

The proposed interweave offers additional dyadic resourcing to facilitate resolution of attachment trauma. The literature on attachment and social engagement in mammals is replete with evidence of the salience of eye-gazing between parents and children, as well as between adults. The *I-Gaze protocol* involves an interweave in which the therapist sits knee-to-knee with the client and gazes into one of the client's eyes throughout phase four, utilizing bilateral tapping as the dual attention stimulus. It is proposed that this recapitulation the original parent-infant attachment paradigm can enhance dyadic resourcing and install a profound felt-sense of earned secure attachment within the intersubjective realm of the therapeutic relationship.

## METHODS

### Setup Procedure (Phase 3):

1. Identify the target
  - Recent: abandonment, rejection, aloneness
  - Past: childhood neglect, abuse with abandonment; “still-face” caregiver
  - Present state: no identifiable memory, but the felt-sense of aloneness
2. Identify the eye with greatest connection to the felt-sense of *aloneness*
  - Have client cover each eye separately and report affect, sensation, cognition, and SUD
  - Choose eye with greatest SUD\*
    - \*Unless it is too far outside the window of tolerance
3. Sit Knee to Knee with the client\*
  - \*or as close as client can tolerate
4. Client thinks about target, focuses on *felt-sense*, and stares into therapist's *dominant eye*

### Processing procedure (phase 4):

1. Tap on client's knees alternately\*
  - \*or have client do butterfly hug as needed
2. Pace client's breathing
3. Maintain steady gaze & think nurturing, complimentary thoughts
4. Relax your face, let your attachment system do the work
5. Continue procedure for 1 – 2 minutes
6. Break off and both breathe deeply
7. Debrief experience with client
8. Compare client's report to your own subjective experience
9. Assess progress: if it is going well, continue
10. If the client is not progressing after two sets, do one or more of the following additions *while maintaining mutual eye-gaze*:
  - a) *Read my eye* interweave
  - b) *Healing light* interweave
  - c) *Eye-zone differential* interweave
  - d) *Intervention of the adult self resource*

#### A. The *Read My Eye* Interweave:

“As you gaze into my eye, read the message my eye sends you”

- Two longish sets, as before
- Be prepared that client may not get a signal, or may misinterpret
  - I recommend sets of 1 – 2 minutes or more
  - Do at least two sets of this and assess

#### B. The *Healing Light* Interweave:

“As you gaze into my eye, imagine you see a healing light come from my eye into yours and go into your core...”

- Longish set, then assess
- Install any positive felt-sense and try on a PC: *I have myself, I'm okay*

#### C. The *Eye-Zone Differential* Interweave:

- Ask client to rotate his/her head so as to “peer” at therapist's eye through different zones
- Ask client to be curious about any perceived differences
- Use those differences to pendulate, titrate, or install as appropriate

#### D. The *Intervention of the adult self* interweave

- Have client imagine adult self comforting child self
- Reverse roles: child perspective comforted by adult self
- Install felt-sense + PC “I have myself”

## Case Study

### Thelma: Preoccupied Attachment Style

“Thelma “was a 43 y.o., once married White female living with her husband and their 10 y.o. son and her husband's 20 y.o. son from a first marriage. Thelma and her husband came into couples therapy to address conflicts surrounding the 20 y.o. It soon became apparent that Thelma's insecurity was at the root of many difficulties. She struggled with holding her husband accountable, or would feel guilt and fear when she did so, requiring reassurance from him afterwards. She felt she was “damaged goods” and that her husband would eventually agree that she is worthless and abandon her. She was jealous of her husband's friendships with other women. She was disgusted at her own body image. She found it difficult to receive care or love and found it hard to believe it was real.

### History

Thelma's parents divorced when she was 5y.o.; she did not know her father who abandoned the family. Her mother, whose own family was replete with stories of sexual and physical abuse, left Thelma home alone from age 12 on for extended periods of time. Thelma described her mother as cold and uncaring; she did not recall being comforted by her. Rather, Thelma found comfort in riding and caring for horses at a neighbor's farm. Thelma was molested by a cousin at age 10; she denied other sexual or physical abuse.

### Assessment and Treatment

Thelma's childhood trauma is one of neglect. She was informally diagnosed with insecure attachment of the preoccupied type, and body dysmorphic disorder (BDD). She was seen for 57 sessions over 33 months, including 12 couples therapy sessions. 12 sessions involved phase four EMDR desensitization; 7 of these utilized the *I—Gaze interweave*.

The therapy is considered successful with the bulk of the attachment work occurring in the first 9 months (22 sessions) of therapy. The remainder of the treatment focused primarily on integrating new learning and behaviors with her husband, child, and peers. She has been free of insecurity symptoms or BDD for 6 months. Notable in this course of treatment were Thelma's responses to EMDR aided with the *I—Gaze interweave*.

Targets focusing on early childhood neglect or abandonment triggered depersonalization, dissociation of affect, and disgust. The use of *somatic interweaves* (Litt, 2012) kept Thelma grounded, and the *I—Gaze interweave* facilitated acceptance of herself as worthy of care. She described the experience as feeling a calming, “warm energy.” Thelma accepted positive cognitions of *I have myself* and *I can take care of myself*. She became comfortable confronting her husband as needed without seeking his immediate reassurance. She no longer worried about him leaving her or looking at other women. She was more accepting of her body image.

Significantly, Thelma cared for her mother as the latter was dying of cancer. Her mother remained dismissive and hostile to the end, yet Thelma did not personalize these interactions and was able to set limits with her mother. She accepted that her mother is someone who could not be pleased, and Thelma felt good about her final act as a loyal daughter.

### Discussion

Based on clinical impression, Thelma progressed into earned secure attachment. Her sense of security with her husband improved such that she could set limits with him and tolerate his displeasure, and she felt no need to avoid or pull away from him. She began to see him as an equal with limitations of his own. She no longer worried about her weight and was accepting of her body image. She set limits with her mother and did not tolerate the latter's criticism or dismissive behavior. Moreover, Thelma began to scrutinize her friendships and started to let go of those who took advantage of her historic over-giving.

## CONCLUSIONS

Any conclusions from a single case study are speculative at best. Not all cases will yield the same results. The treatment provided had many therapeutic elements, the effects of which cannot be dismantled in this study.

Thelma's attachment disorder was relatively mild; others with more severe attachment trauma would not respond as rapidly. I speculate that her childhood spent caring for horses—a social mammal—played a large part in her ability to mentalize and seek comfort in relationship. Thelma may have progressed without any specialized interweaves. Notable is how rapidly she internalized a secure sense of self.

It is also remarkable that the *I—Gaze interweave* has not provoked an erotic transference from any of my clients: male or female, straight or gay, young or old. While a few have remarked that they wish they could take my eye home with them, all have recognized that this intervention is about self-care. None have believed that their relief was coming from or depended on the therapist, or that their therapist was inviting an inappropriate relationship.

The *I-Gaze interweave* described here is designed to intensify non-conscious decoding of the client's non-verbal communication (e.g., eye-gaze, facial expression, prosody), which leads to genuine empathy in the therapist (Schoore, 2003) and activates an implicit affect regulatory system in the client (Porges, 2009; Greenberg, 2007).

The empathy generated organically by the method's intense right-hemisphere dominated communication constitutes “new,” real-time information to the client. This contradicts the client's “old” information: rejection, dismissal, or contempt—residing in implicit autobiographical memory. Thus, the dual attention aspect of the adaptive information model is conserved. Bilateral stimulation is administered by tapping, the *butterfly hug* (Artigas, Jarero, Alcalá, & López Cano, 2009) or *bilateral* tones. When the client actually “sees” and can receive the care and acceptance from the therapist, the mismatch between implicit expectation and actual sensation/perception creates a prediction error. Prediction error creates a window of memory lability in which the dysfunctionally stored (linked) memory can be updated (Chamberlin, 2015; Ecker, Ticic & Hulley, 2012).

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Contact me at [barrylittmft.com](http://barrylittmft.com)



Mutual gazing between Mother and Infant



The *I—Gaze Interweave* utilizes mutual eye-gaze to activate the attachment system