The

*I–Gaze Interweave*

for

Attachment Repair in EMDR Therapy

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The Domains of Self

Implications for:

Phase 3 (setup)
and
Phase 4 – 5 (desensitization and installation)
Working with Domains of the Self

Being vs. Nothingness

Merit

Safety

Litt, 2007b
Domains of the Self, continued

- Being vs. Nothingness
- Being vs. Nothing
- Self-Other Dialectic
- Attachment Trauma
- Depersonalization
- Merit
  - Neurosis
- Safety
  - Hypervigilance

Litt, 2007b
Cognitive Correlates to Domains of the Self

- **Being vs. Nothingness**
  - I don’t exist’
  - I’m invisible
  - I don’t matter

- **Merit**
  - I’m not good enough
  - I don’t measure up
  - I’m a failure
  - I’m bad

- **Safety**
  - I’m gonna die
  - I’m not safe
  - I’m trapped

Litt, 2007b
Shock or Disbelief
(a.k.a. peritraumatic dissociation)

• Some traumas seemed to be locked in a state of psychological shock
  – Sudden onset
  – Perpetrator behavior unexpected or anomalous

• Event not integrated with narrative memory
  – Does not process well; affect blocked
  – ANP cannot accept the event

• Typical client presentation:
  – I know it happened, but I can’t believe it
Assessing and Treating Shock/Disbelief*

During Setup Phase (Phase 3):

1. Have client cover one eye
2. Ask: Give me your gut response—can you believe it?
3. Get a SUD for “Disbelief”
4. Repeat with other eye

*Adapted from Cook & Bradshaw (2002)
Assessing and Treating Shock/Disbelief*

During Setup Phase (Phase 3):

5. Perform DAS with Lower SUD eye
6. Continue DAS until SUD = 0
   • Yes, I really believe it happened
7. Repeat with other eye
8. Repeat with both eyes
9. Resume Setup anew
Features of the "Being" Domain

- **Behavior**: Acting-out
  - (Better to be *bad* than to *not be* at all)
  - Relational conflict and ego state conflict may be “trading up” from *not being*
    - Cutting; substance abuse; O-C D; etc.

- **Affect**: shame, anxiety, panic, fear

- **Sensation**: numbing, tonic immobility

- **Knowledge (NC)**: I’m alone, invisible…
  (Nihilism)
The Natural Progression of Emotional Experience

Diagram showing the natural progression of arousal over time.
The Pathological Progression of Emotional Experience

- Distress Intolerance
- Shame
- Dissociation:
  - Numbing
  - State Shift
  - Fugue
Working Through the Being Domain

The Importance of Sensation:

• *I think, therefore I am*
  
  -Descartes

• *I notice that I feel, therefore I am*
  
  -(Damasio/Litt)
Working Through the Being Domain

• Event Targets
  - Rejection
  - Abandonment, separation, loss
  - Associations

• Dynamic Targets:
  - Narcissistic partner
  - Partner avoids/withdraws
  - ”As-if” relating
Working Through the Being Domain

- **NC**: I don’t exist; I’m invisible; I’m alone; I don’t matter

- **PC**: I am; I have myself; I exist even if…
**Working Through the Being Domain**

- Somatic regulation must be maintained
  - Clients often are outside the window of tolerance
  - Sensory integrity necessary for processing
  - EMDR augmented with somatic techniques
- Ensure that clients are *mostly* embodied at closure
Working Through the Being Domain

- Anxiety may present as a phobia of underlying shame
- Successful processing may “trade up” from numbing or fear to shame
- Shame reactions can be mapped by Nathanson’s (1992) Compass of Shame
Nathanson’s (1992) Compass of Shame

Withdraw

Attack Other

Avoid

Attack Self
The Malignant Shame Spiral
Successful Resolution of the Being Domain Entails:

- Increased distress tolerance *vis a vis* insecure attachment signals from significant others
  - EMDR with Trauma Focus
- Acceptance of *existential aloneness*
  - Mourning
- Development of *earned secure attachment (starting with the therapist)*
  - Trust building -- Self Trust
- Development of Object Constancy (acceptance of the Self Object)
  - Attachment focused EMDR; Imaginal Nurturing
Working Through the Being Domain

Specific protocols for doing attachment therapy:

- Affective Circuit Restructuring (Paulsen, O’Shea, Lanius, 2014)
- Attachment-Focused EMDR (Parnell, 2013)
- *I — Gaze* Protocol (Litt, 2016)
The Merit Domain
The Merit Domain

• **Trauma therapy:**
  – worth issues defined by discrete event
  – Goal: Comparative self worth

• **Contextual therapy:**
  – worth/merit issues contextualized (defined by the loyalty system)
  – Goal: Differentiation of Self
    • Enhanced capacity to participate in trust-based relationship
    • Existential Self Worth
Working through the Merit Domain

• Successful resolution entails Mourning

• Transformation of shame yields compassion for self and others

• Typical NCs are expressions of comparative worth defined by the family, community, culture:
  – Avoid PCs that reify the same paradigm
  – PCs should express existential worth:
    – I’m okay; I am
Successful Resolution of the Merit Domain

• Resolution entails acceptance of:
  - Existential worth: I am
    - Shifting from an adjective to a verb
  - Existential Powerlessness: I’m powerless (and that’s okay)

• Shame narratives do not gain traction: the trait becomes a state

• Increased distress tolerance = less avoidance
The Tootsie Pop Phenomenon

When Domains Collide: Being vs. Merit
Merit Domain:
- Anxiety, obsessions, perfectionism,
- Phobia of the Chewey Chocolatey Center

Being Domain:
- Attachment Trauma
- Aloneness
- Depersonalization
Clinical Presentation of the Tootsie Pop

• Presenting problem and dominant symptoms are anxious, obsessive, and/or perfectionistic
• May have stable (if unsatisfactory) relationships
• Catastrophic endpoint is being alone
• Response prevention stimulates depersonalization (symptoms)
Working with Tootsie Pops

• The *Being Domain*—not the *Merit Domain*—drives the anxiety
• Client must set aside the anxiety narrative and drop into the *felt-sense* of aloneness
  – This may be a preverbal memory
• *It is from this state that attachment works proceeds*
Features of the “Safety” Domain

- **Behavior**: avoidance, hypervigilance
- **Affect**: anxiety, panic, fear
- **Sensation**: autonomic hypoarousal
- **Knowledge (NC)**: *I’m gonna die, I’m not safe*...
Working through the Safety Domain

- Therapist and client work together to maintain some control over fight/flight response
- Controlled and organized activation of fight/flight motor behavior during desensitization phase
- Client attention to *present* condition of body while remembering threat event
Temporal Safety

• Vision-Touch Synaesthesia: the Rubber Hand Illusion (Botvinick and Cohen, 1998)
• Attention to real-time sensory cues vs. remembered or anticipated states
• Temporal safety as associative vs. “safe place” (dissociative)
Successful Resolution of the Safety Domain

• Acceptance of role of chance in everyday life (vs. magical thinking)
• Attention to *temporal safety*
• Resetting autonomic nervous system to increased parasympathetic tone
The Zone of Optimal Arousal

Stability and Safety in Phase 4

Involves the manipulation of two crucial variables for reprocessing:

1. Absorption (or, Dual Attention)
2. Autonomic Arousal
   - Fight-Flight
   - Freeze/Submit
   - Tonic Immobility
A Healthy Nervous System

Normal (Non-Traumatic) Variation

http://www.traumahealing.com/somaticexperiencing/index.html
Symptoms of Un-Discharged Traumatic Stress

- Dominant ANS
  - Social Engagement (ventral vagal - Parasympathetic)

Stuck on "On"

Stuck on "Off"

Primitive Parasympathetic

http://www.traumahealing.com/somaticexperiencing/index.html
Zone of Optimal Arousal for Processing

- Hypoaroused: Absorption, Submission
- Hyperaroused: Abreaction, Panic

- Tonic Immobility

- Depersonalized
- Presence
Techniques to Decrease Absorption

- Distraction (e.g., breath cueing aloud)
- Present-time Orientation
- Variable Rhythm of DAS
- Somatic Cueing
- Olfactory Cueing
- Third Person Visual Perspective
Techniques for Increasing Absorption

- Closing the Eyes
- Steady Rhythm of DAS
- Pushing the NC
- Silent Breath Cueing
- NC in Native Language
- First Person Perspective
- Postural Cueing

Submission  Tonic Immobility  panic

Hypoaroused  Sympathetic
Part 3: Somatic Interweaves
(to manipulate autonomic arousal)

• Goal: Keep the client safely embodied for trauma processing

• Objective:
  – Organize the motor response to the trigger
  – Regulate Autonomic activation
  – Regulate breathing
  – Maintain somatosensory awareness and present time/place
Somatic Interweave for *Parasympathetic Hyperarousal*

- States include: Freeze, tonic immobility, depersonalization, submission
- Objective: “reboot” the ANS
- Method *(during desensitization)*:
  - *Kneading toes* interweave (light duty)
  - *Marching Feet* interweave *(medium duty)*
  - Add *Isometric pushing* (medium duty)
  - *Two-arm pushing with resistance*
  - *Cross-Crawl*
Somatic Interweave for *Sympathetic Hyperarousal*

- States include: panic, rage, hyperventilating, desire to act-out aggression
- Objective: organize the motor response to promote resolution
- Method: (during desensitization):
  - *Rage Dump*
  - *Marching Feet*
  - *Fantasy Aggression with slowly moving limbs*
  - *Two-Arm Pushing with/without resistance*
    - *Static Version*
    - *Dynamic Version*
Techniques to Decrease Absorption

- Distraction (e.g., breath cueing aloud)
- Present-time Orientation
- Variable Rhythm of DAS
- Somatic Cueing
- Olfactory Cueing
- Third Person Visual Perspective
Techniques for Increasing Absorption

- Closing the Eyes
- Steady Rhythm of DAS
- Pushing the NC
- Silent Breath Cueing
- NC in Native Language
- First Person Perspective
- Postural Cueing
Somatic Interweaves *(Phases 4—7)*

Goal: Keep the Client safely embodied for trauma processing

Objectives:

- Organize the motor response
- Regulate autonomic activation
- Regulate breathing
- Maintain somatosensory awareness

*Always maintain Present Time Awareness*
Somatic Interweaves for Autonomic Hyperarousal

States include:
• Panic
• Rage
• Hyperventilating
• Desire to Act-Out

Objective:
• Organize the motor response to promote resolution

Methods (during phase 4)
• Rage Dump
• Marching Feet
• Fantasy Aggression
• Slow motor impulse
• Two-Arm Push
  – With/without resistance
  – Static or dynamic version
Somatic Interweaves for Parasympathetic Hyperarousal

- States include: Freezing, tonic immobility, depersonalization, submission
- Objective: “reboot” the ANS
- Method (During desensitization)

- Kneading Toes
- Marching Feet
- Isometric Pushing
- Two-Arm Pushing
  - Without resistance
  - With resistance
- Cross-Crawl
The
I – Gaze Protocol
for Attachment Trauma
Setup Procedure:
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
I – Gaze Protocol, continued

Setup Procedure:

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
I – Gaze Protocol, continued

Setup Procedure:

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
I – Gaze Protocol, continued

Setup Procedure:

5. Do an absorption set with horizontal eye movements

6. Assess reactivity in each of three zones within the field of view

7. Choose the eye-zone you will start working with
Working with Eye Zones

Step 4. Assess the reactivity for each Zone, including SUD

SUD = 8  7  4
I – Gaze Protocol, continued

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 thoughts
4. Relax your face, let your attachment system do the work
I – Gaze Protocol, continued

Processing procedure (phase 4), continued

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 interweaves:
   - *Read my eye* interweave
   - Healing light interweave
   - *Eye-zone differential* interweave
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
I – Gaze Protocol, continued

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*
I – Gaze Protocol, continued

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
Working with Eye-Zones

Therapist

Client

Client rotates head to move through zones
Closure (Phase 5 – 8):

10. Repeat procedure with both eyes open
   • Client gazes into therapist’s dominant eye as before

11. Client rotates head to peer through each of the three eye-zones

12. Therapist looks into same eye, blinks, looks into second eye
Closure (Phase 5 – 8): *Imaginal Nurturing Interweave*

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

Where Transference and Countertransference Merge
I – Gaze Protocol: the Intersubjective Space

• This intervention directly accesses the internal working model (IWM) of attachment for both therapist and client
• Client reactions will reveal his/her IWM
• Transference distortions may include:
  – Projection of contempt or anger on therapist
  – Visual distortions
  – Dissociation: blanking out; numbing
  – Inability to read therapist’s intention
I – Gaze Protocol: the Intersubjective Space

• Therapist must be able to access his/her own Secure IWM
  – *Otherwise, fuggettabottit*

• Therapist will *feel* client’s insecure IWM:
  – Therapist gets distracted; cannot maintain gaze
  – Therapist sees fear, shame, rage on client’s face
  – Client may look much younger

  *Trust your internal reaction: it’s diagnostic!*
I – Gaze Protocol: the Intersubjective Space

• Therapist will also feel *flow* of secure attachment with client
  – Gazing feels more natural, easy
  – Therapist may sense pulse of warmth
  – Client may appear more calm, confident

• Client may report feeling “solid,” grounded, calmer

• Client may spontaneously endorse PC