Integral Eye Movement Therapy (IEMT) - An Adaptive Model

Based on Sr. Callista Roy’s (1970) Adaptation Model

Nursing theories frame, explain or define the practice and delivery of nursing care. There are a number of prominent models in common use, and different models may be used according to the organisational needs and the provisional requirements of the patient group served.

Sister Callista Roy developed the Adaptation Model of Nursing which quickly became regarded as a major nursing theory worldwide, especially in rehabilitation environments. Roy's model sees the individual as a set of interrelated biological, psychological and social systems. Whilst the individual strives to maintain a balance between these systems and the pressures of the outside world, an ideal level of balance is rarely found, thus the need for continual adaptation.

Overview of the theory

NEEDS REWRITING TO AVOID PLAGIARISM

This model comprises the four domain concepts of person, health, environment, and nursing; it also involves a six-step nursing process. Andrews & Roy (1991) state that the person can be a representation of an individual or a group of individuals.[1] Roy's model sees the person as “a biopsychosocial being in constant interaction with a changing environment”.[2] The person is an open, adaptive system who uses coping skills to deal with stressors. Roy sees the environment as “all conditions, circumstances and influences that surround and affect the development and behaviour of the person”.[1] Roy describes stressors as stimuli and uses the term residual stimuli to describe those stressors whose influence on the person is not clear.[1] Originally, Roy wrote that health and illness are on a continuum with many different states or degrees possible.[2] More recently, she states that health is the process of being and becoming an integrated and whole person.[1] Roy's goal for nursing is “the promotion of adaptation in each of the four modes, thereby contributing to the person's health, quality of life and dying with dignity”.[1] These four modes are physiological, self-concept, role function and interdependence.

Roy employs a six-step nursing process: assessment of behaviour; assessment of stimuli; nursing diagnosis; goal setting; intervention and evaluation. In the first step, the person's behaviour in each of the four modes is observed. This behaviour is compared with norms and is deemed either adaptive or ineffective. The second step is concerned with factors that influence behaviour. Stimuli are classified as focal, contextual or residual.[2] The nursing diagnosis is the statement of the ineffective behaviours along with the identification of the probable cause. This is typically stated as the nursing problem related to the focal stimuli, forming a direct relationship. In the fourth step, goal setting is the focus. Goals need to be realistic and attainable and are set in collaboration with the person.[1] There are usually both short term and long term goals that the nurse sets for the patient. Intervention occurs as the fifth step, and this is when the stimuli are manipulated. It is also called the 'doing phase' .[2] In the final stage, evaluation takes place. The degree of change as evidenced by change in behaviour, is determined. Ineffective behaviours would be reassessed, and the interventions would be revised.[1]

The model had its inception in 1964 when Roy was a graduate student. She was challenged by nursing faculty member Dorothy E. Johnson to develop a conceptual model for nursing practice. Roy's model drew heavily on the work of Harry Helson, a physiologic psychologist.[3] The Roy adaptation model is generally considered a “systems” model; however, it also includes elements of an

“interactional” model. The model was developed specifically for the individual client, but it can be adapted to families and to communities (Roy, 1983)[full citation needed]. Roy states (Clements and Roberts, 1983)[full citation needed] that “just as the person as an adaptive system has input, output. and internal processes so too the family can be described from this perspective.”

Basic to Roy's model are three concepts: the human being, adaptation, and nursing. The human being is viewed as a biopsychosocial being who is continually interacting with the environment. The human being's goal through this interaction is adaptation. According to Roy and Roberts (1981, p. 43)[full citation needed], ‘The person has two major internal processing subsystems, the regulator and the cognator.“ These subsystems are the mechanisms used by human beings to cope with stimuli from the internal and external environment. The regulator mechanism works primarily through the autonomic nervous system and includes endocrine, neural, and perception pathways. This mechanism prepares the individual for coping with environmental stimuli. The cognator mechanism includes emotions, perceptual/information processing, learning, and judgment. The process of perception bridges the two mechanisms (Roy and Roberts, 1981)

Embedded within the operating mechanism of IEMT is a fundamental assumption that holds a person as a dynamic being who is in constant interaction with the ever-changing environment. Human beings are an intricate design of biological, social and psychological factors, both internal and external.

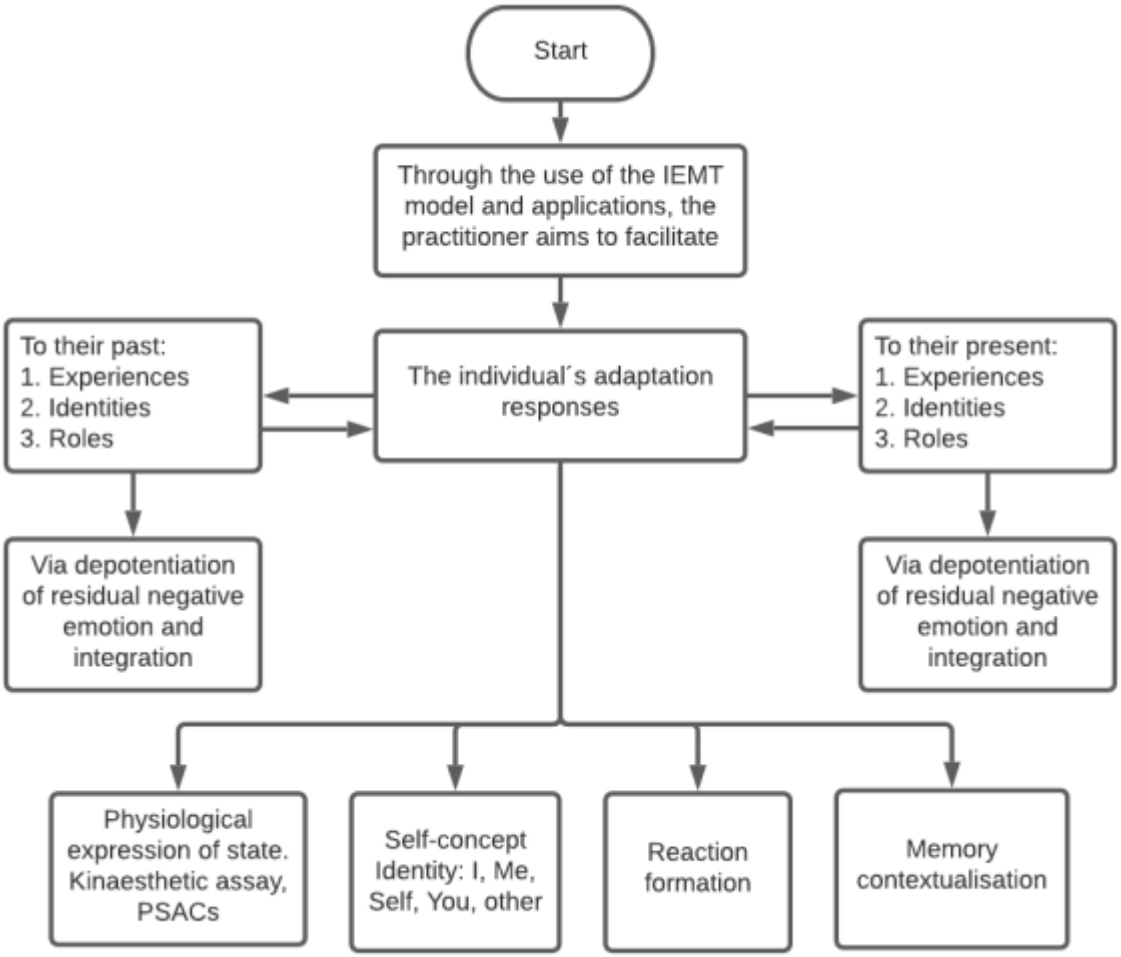
Every environment offers the individual resources, challenges, struggles and stressors of different forms and variable degrees thereby resulting in all consequential effects being subjective and occurring on a spectrum.

An important aspect of IEMT is an increase in resilience in order to get the client more effective to face, handle and adapt to the current environment. IEMT attempts to increase adaptability and maturity on part of the individual in order to manage life and its' ongoing complexities.

Being an “adaptive system”, a person has input from the environment, which is subject to internal processing, eventually leading to an output. Our model presumes that the individual uses both innate and acquired (learned) mechanisms to adapt. Some of these adaptations may bring about unintended negative consequences and may be termed maladaptive.

The environmental stimuli that present as a resource, challenge, stressor or any combination of these may have its’ origin in the historical biography of an individual. This, in turn, can exert an effect in the present through its psychological, physiological, emotional, social and/or environmental nature.

The Adaptive IEMT Model states that well-being is an integral and central feature of a person’s life, and can be represented on a well-being/distress spectrum. Along with health, well-being can be described as a state and process of being and becoming integrated and whole as a person, freed from the negative historical stresses and maladaptive responses.

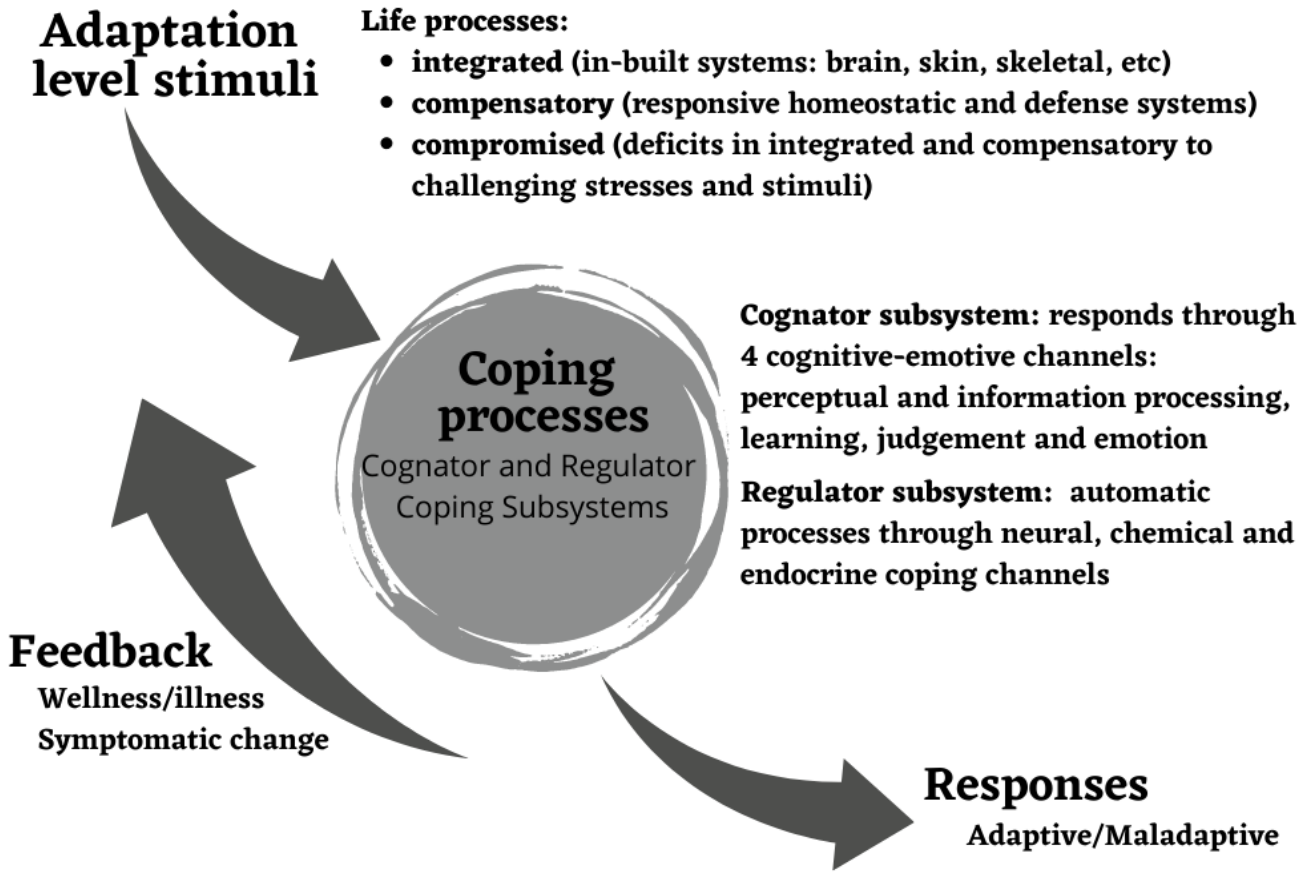


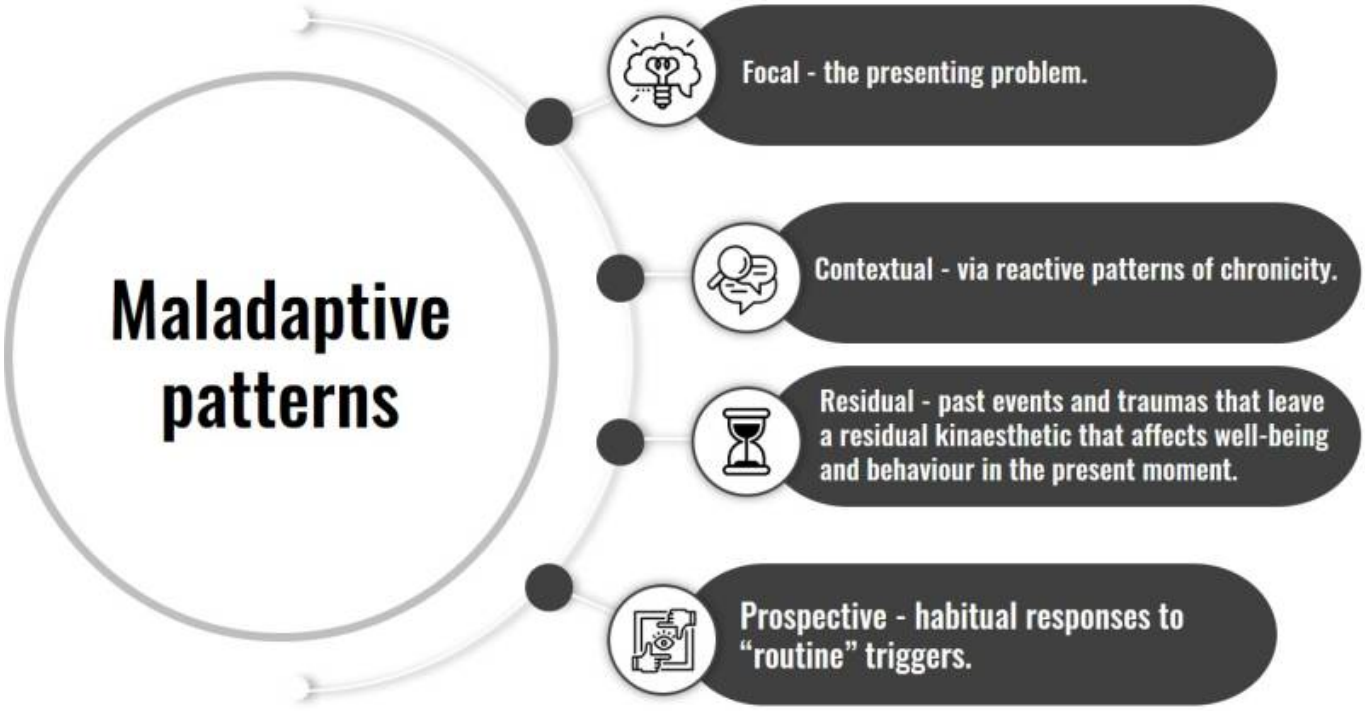
The environment has four components:

1. **Focal** - current and specific stresses (extraneous pressures, intrinsic health issues) applied to the individual present in many or all contexts;
2. **Contextual** - all context-dependent stimuli, that is, those present in the background, and frame the situations that exacerbate the consequences of the focal stresses;
3. **Residual** - historical stresses whose after-effects continue into the current situation and affect the individual’s well-being. This may include attitudes, beliefs and strong influences in the form of either people or experiences.
4. **Prospective Stresses** - can reasonably be known, anticipated and expected prior to their occurrence.

With the IEMT model, well-being is affected when an individual’s adaptation fails to de-potentiate residual negative states resulting from historical environmental interactions and pressures. This in turn leads to specific maladaptive patterns, The Patterns of Chronicity, which inadvertently serve to maintain the residual negative state.

1. **Focal** - the presenting problem
2. **Contextual** - via reactive patterns of chronicity
3. **Residual** - past events and traumas that leave a residual kinaesthetic that affects well-being and behaviour in the present moment
4. **Prospective** - habitual responses to “routine” triggers


Adaptation level stimuli
Life processes:
integrated (in-built systems: brain, skin, skeletal, etc)
compensatory (responsive homeostatic and defense systems)
compromised (deficits in integrated and compensatory to challenging stresses and stimuli)
Coping processes
Cognator and Regulator Coping Subsystems
Cognator subsystem: responds through 4 cognitive-emotive channels: perceptual and information processing, learning, judgement and emotion
Regulator subsystem: automatic processes through neural, chemical and endocrine coping channels
Feedback
Wellness/illness
Symptomatic change
Responses
Adaptive/Maladaptive


Maladaptive patterns
Focal - the presenting problem.
Contextual - via reactive patterns of chronicity.
Residual - past events and traumas that leave a residual kinaesthetic that affects well-being and behaviour in the present moment.
Prospective - habitual responses to "routine" triggers.

The IEMT Adaptive Model makes fifteen operating assumptions.

1. The person is a dynamic system that operates within the web of biological, psychological and social influences.
2. The person is a product of his/her interaction with an ever-changing environment.
3. Well-being, eustress and distressing stressors are an in-built part of human life.
4. The environment is embedded with stressors and changes. Adaptation is not a choice, but a necessity for life.
5. The adaptation of an individual is a function of the relationship between the flexibility and skills of adaptation and the familiarity and degree of the stimuli.
6. All behaviours are learned within a socio-cultural context.
7. No symptom of distress exists in isolation from this context.
8. Maladaptive emotional responses can give rise to patterns of chronicity that inadvertently serve to maintain a distressed state and prevent natural healing across time.
9. There is a dynamic objective for existence with the ultimate goal of achieving dignity and integrity.
10. Movement of the eyes while thinking of an unhelpful memory changes the contents of the memory and the feelings/reactions attached to the memory.
11. A person can be reduced to parts for therapeutic change work and then needs to be looked at as part of the whole.
12. IEMT is based on the principle of causality. Feelings, emotions, roles, identities and events have a cause. Each experience sets up an effect in motion.
13. A patient’s behavioural, emotional and cognitive patterns can be challenged effectively by the IEMT model.
14. A positive and effective state of adaptation leads toward greater integration in an individual and also frees a person’s energy to respond to other stimuli.
15. A limitation of IEMT is to only be able to make changes to the body's conditioned reflex responses, IEMT cannot, for example, change the genetics of a body, although it is hypothesised that further research could well find epigenetic adaptations occurring as a result from working with PTSD clients.

Goal and Intention of IEMT

The goal of IEMT is to free the client from the effect of negative memories, feelings of distress and constricted identities that restrict the fundamental idea of life which is to experience it fully. It is to know and imbibe that stressors are integral to living and our adaptability to them defines well-being. Therefore, IEMT gives an empowering choice to stay on the spectrum towards robust health, in all domains, physical, mental, social and spiritual.

The intention of IEMT is the integration of experience and maturing of identity thereby leading to increased well-being within the dynamic system called the human being.

An integrated individual with greater well-being is more contributive to self and their social environment invariably leading to a better quality of life.

Steps of IEMT

1. Addressing a troublesome memory and mitigating the impact of unpleasant feelings
2. De-linking the cognate emotion-physiologic-memory web (separating stimuli and response) by identifying patterns of distress and specific stimuli
3. Increasing awareness of the maladaptive behaviours (“Patterns of Chronicity”) that hinder healing and evolution
4. Identifying triggers within the body-mind loop
5. Introducing choice towards any frame/ state of mind
6. Evaluation of the intervention in the real world