Integral Eye Movement Therapy

«««*do not delete this: please keep everything completely factual without hyperbole. Please remember this is not a platform to self advertise or to promote yourselves. Also, this needs to be mostly meta-data, i.e. we arent teaching IEMT training here, but giving the background and support information about it. I recommend you write up your contribution on your computer first and then copy and paste here, in case of mishaps.*

Background and Development

Integral Eye Movement Therapy was originally developed out of Steve and Connirae Andreas' model of Eye Movement Integration. This followed the observation of a number of neurological phenomena that occur during the therapeutic eye movements occurring at the moment that the problematic imagery changed its emotional coding. Then there was the development of a specific set of applications of these phenomena that enabled Integral Eye Movement Therapy to be applied to the areas of neurological imprints specifically, imprints of emotion and some of the imprints of identity.

Emotional Imprints

Emotional Imprint occurs when a person has an event with high intensity of emotional (usually) distress and the hippocampus registers a memory which is highly associated with a Fight or Flight response from the amigdala.

Thus creating a painful memory. Some people call it an Unfinished Business.

That memory is actualy a derivation of the event as it was registered at that specific time. Because every time that the person accesses that derivation he feels the pain from the Amigdala, so he wants to avoid that pain. in order to do so, the person develops a whole lot of behaviours, values and belief sets. In some cases one can notice extreem behaviours. black or white types of behavioural or emotional shifts.

With the use of the K Protocol in IEMT, it is possible to clear that Emotional Imprint, so the person has a different derivation of the memory. by having a different derivation of it, he has different emotions arise, which allows him to reprocess the memory and store it differently. By that changing beliefs, values, behaviours and especially triggered emotions.. so specific triggers do not trigger the person in the same manner again.

Identity Imprints

Identity imprinting occurs during life long development and is constantly evolving and changing. Many aspects of identity are attributed and occur neurologically as a feedback response to the

environment. An example of this is the production worker who yesterday was “one of the boys” and today, following promotion to lower management, is now officially an enemy to his former friends and colleagues.

Other deeper aspects of identity are more permanent and “feed-forward” into the environment. These are the aspects of identity that tend to occur in all contexts, with some being more stable than others. Examples of this are gender identity, identity as a father/mother, brother/sister and so forth. However, some aspects of identity are much more flexible or unstable and may change according to context.

Thus, IEMT also addresses the issue of, “How did this person learn to be this way?” In some cases, the person can adopt aspects of identity that can be problematic. For example, an emotional imprint might be, “I feel unhappy” whilst an identity imprint might be, “I am an unhappy person” or even, “I am a depressive.”

By specifically addressing the identity imprint this enables the therapist to bypass the beliefs that often support the undesired identity such as, “I cannot do that because I am a depressive” and so forth.

Patterns of Chronicity

A pattern of chronicity constitutes resistance to therapy through the client's identification with a belief supporting the problem. It is an advanced model of early identification of difficulties that may prevent an effective therapeutic process. It is based on the analysis of the ways in which the client expresses him/her self verbally.

When the therapeutic process aims at helping the client solve the problem, the client may experience it as a threat to the elements of his/her identity structure. The patterns of chronicity allow the client to inadvertently avoid involvement in the change process or even to sabotage it. IEMT offers the model of recognition of those patterns and helps the therapist to cross the barriers that would otherwise prevent the client from improving his/her condition.

IEMT identifies five major patterns of chronicity:

1. The three-stage overreaction.
2. The maybeman.
3. The big “what if” question.
4. Testing for existence of the problem rather than testing for change
5. “Being at effect” rather than “being at cause”

The three-stage overreaction pattern

This is a pattern resulting from the conviction of some clients that the facilitator should act according to their expectations. When a client experiences undesirable emotions, he/she may try to transfer the responsibility for that onto the therapist and expected from him to make changes to the process. This attitude of the client often results in three steps leading to “punishing” the therapist who does not obey.

Stage 1. Signal

This is the first stage of the pattern leading to punishment - it manifests itself as an expression of dissatisfaction with the process and usually consists in an indirect warning about an emotional reaction.

For example, “I don't like the fact that we're talking about this issue, I think you should address another topic.”

Stage 2. Signal amplification

The second stage involves a direct threat and takes the form of firm opposition, usually through emotional blackmail.

For example, “If we continue to talk about this, I’m done with this session.”

Stage 3. Overreaction - punishment

This is the client's extortion of will, manifesting itself in a strong emotional response (overreaction) and making it difficult or impossible to continue to work in a constructive manner.

E.g. taking offence, staying silent, leaving etc.

The maybeman

A pattern called the maybe-man is an expression of uncertainty of the client's own feelings and/or beliefs.

Often it results from insufficient engagement or immersion of the client in his feelings. It is expressed in a language characterized by terms that lack precision and clarity. It is based on descriptions and statements rich in generalizations and lacking specific content. In some cases, it may also constitute a subconscious resistance of the client's psyche against realizing a solution that he/she is not ready for and therefore prevents him/her from having a clear view of the problem.

The simplest example is the inaccurate determination of one's emotions on a numerical scale: “I feel stressed out at a level of... somewhere between five and six out of ten.”

The big "what if" question

This pattern is based on the question “What if...?”, by means of which the client tries to find a gap in a given approach or solution.

Usually, the person asking this type of question has a ready answer, which he or she would not verbalize. Often the question 'what if X?' is intended to imply an answer of then Y, where X is a single example of a potential difficulty that is intended to overturn the legitimacy of the planned actions, and Y is a negative consequence of that overturn.

For example, this may happen when a client analysing his/her possibilities of solving a problematic situation concludes the need to change an unfavourable habit. In case he/she does not want to introduce this solution, they may come up with this chronicity pattern. “What if?” questions are very rarely an authentic attempt to obtain knowledge. Rather, they are only an attempt to challenge the validity of what is being discussed, or what is found to be a solution.

For example, a man who comes to the conclusion that he should start to show his feelings to his partner in a way that is more consistent with the way she expects it from him, he may use the question: “What if she doesn't appreciate it anyway?”. Such a question implies a belief that the answer would be: “Then my efforts will be in vain”.

Testing for existence of the problem rather than testing for change

The fourth pattern of chronicity is characteristic for those who tend to verify the progress of the process in terms of finding the remaining of the problem rather than noticing the change being introduced.

People who in their observations omit a 99 per cent change for the better and focus on 1 per cent of the remaining problem are those who require special help from the therapist in finding the balance and rationality of their filters. This pattern can undermine effective change work and suppress any benefits achieved.

“Being at effect” rather than “being at cause”

People who see themselves as subjects of problems can thus limit their ability to influence the situations in which they find themselves.

This is a pattern that requires particular attention, sensitivity and insight, to avoid unintentional suggesting to somebody, who is an actual victim of people or external factors, that they are responsible for what has happened to them. Inexperienced personal development practitioners, but also professional psychologists, sometimes promote the idea that “all the problems are in our heads”, which is harmful and counterproductive.

However, in many cases, many people find relief from feeling responsible for their very own decisions, ill-considered actions or inaction, in the belief that they are only a subject to external factors and no change is in their power. If objective facts contradict such a view, it indicates a typical pattern of “being at effect instead of being at cause”.

People who manifest this pattern expect that the help will consist of the work of the therapist and that they will only be its passive recipients. Such an approach excludes the possibility of change and effective help and requires a skilful guide for the client to find his or her agency (which of course will also entail an element of responsibility).

PTSD

IEMT posits that central to the PTSD experience is a shame-based micro-experience that exists below the diagnostic threshold and as a result is usually overlooked by both patient and clinician. Referred to as “the lynchpin” in IEMT, it is claimed that by addressing this micro-experience, or experiences,

flashback phenomena and intrusive imagery common to PTSD are resolved.

PSACs

Physiological State Accessing Cues, is known in IEMT as **PSAC'S** for short. Teaching this process to people is one of the most rapid ways of eliciting a real and tangible change for those who are in various stuck emotional states. We often talk abut how the mind affects the body, and the physiological responses that our thoughts have on the body's chemicals and thus body functionality. However adopting certain physiological stances which have been learned and become automatic responses, can then act as a feedback loop to impact on the brain and increase the intensity of the emotional state that that person is feeling.

It has been seen that when a person experiences trauma one of the physiological responses that can occur is a freeze state for the body, i.e. the freeze part of the fight, flight freeze response. This is a stress response and a survival response in terms of the autonomic nervous system which is beyond the control of the neocortex/conscious functioning of the brain. Dr Steven Porges talks about this 'freeze response' in his book 'The Pocket Guide To The Polyvagal Theory: The Transformative Power of Feeling Safe' talks about the un-myelinated parasympathetic fibres or "C" fibres.

Not everybody locking into particular physiological state will have experienced what is traditionally know as a 'trauma', how ever as seen in when working with PTSD what is trauma to one person can be shrugged off by another. So a person develops a coping strategy that is physiologically based and the stance or position reinforces the strength of the emotions and feelings.

In trauma and PTSD situations, there is a down-regulation social engagement system which can keep people in a state of hyperarousal via the sympathetic part of the autonomic nervous system (myelinated fibres), disconnection via the reptilian un-myelinated vagus or in a coping mode i.e. avoidance. Each of these responses are a way to survive in optimal safety. A persons nervous system can become primed to react to cues based on past traumatic experiences that may not fit with a current situation.

In IEMT we encourage Practitioners to be ever observant of body language. When somebody is talking about an issue and accessing their associated state, shifts in physiology can be detected. This may be very obvious or subtle.

Hence the IEMT Practitioner can use the Subjective Unit of Distress (SUD) scale to ascertain what level of discomfort that person is currently at as the lock into a physiological response. Now by making the person aware consciously of the way that they are holding their body we can elicit small shifts in that physiology and ask the person very simply is this feeling the **same** or **different**? Then we can ask is it **better** or **worse**? If better or worse what score would they give it now? The next step is vital to the process we ask them to **"put your body back to the position it needs to be in order to get back to the original feeling or state"**.

So why are we doing this? Very simply it is to demonstrate to a person who may be totally unaware of the relationship between their physiology and how they feel with the original stance and then with the subtle change in that stance i.e. there is a real and tangible shift. This can often be a big "aha" moment for people to understand that if they want to stop or downgrade the strength of a particular feeling or state all they have to do in the moment is a subtle shift, this make be as simple as move one finger to a different position, sitting back slightly on a chair, turning out or in one foot from the current position, it may even be to take a controlled breath in and out.

Such changes using the PSAC's model is not necessarily creating longterm neurological change in the moment, however over time if a person become more aware of how their body can affect their mind they can start to exercise such changes more regularly and thus with repetition, this can now start to affect neurological pathways.

This very quick, very easy exercise for some people who find it very hard to change at all, may be the first breakthrough that they have ever achieved in suddenly enabling themselves to make changes that can help them to feel better. It is not necessarily going to deal with cause, however if effect is so powerful that therapy can seem impossible, this can be the vert first step towards creating change for the better. This process is something that that person can learn and exercise themselves in situations when a familiar unwanted state can be triggered or created.

How many people for example with low mood or depression wear one particular colour and sit in one particular chair in one particular position and as a result start to run and embed the viscous cycle of their particular physiological state loop? By having this resource skill a person can then make the choice wether to remain locked into a particular state or not. IEMT should be about teaching skills to people and not just "doing therapy" to them.

When teaching this to IEMT students there are other exercises that we can use e.g. with he 'Practitioner' asking the 'Client' to exaggerate stances, or the Practitioner mirroring the stance and they the exaggerate it. Depending on the rapport act has been created between the Practitioner and the Client even elements such as using taboo words or concepts can be used, however this must never be seen to be personal to the client and is merely a way of getting them to see that the behaviour can be changed quickly even via humour.