Integral Eye Movement Therapy

Background and Development

Integral Eye Movement Therapy was originally developed out of Steve and Connirae Andreas' model of Eye Movement Integration. This development followed the observation of a number of neurological phenomena that occur during the therapeutic eye movements, specifically at the moment that the problematic imagery changed its emotional coding.

From this followed the development of a 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 imprints of identity.

Emotional Imprints

Negative emotional imprinting occurs when a person has an event with high intensity of emotional distress and the hippocampus registers a memory which is highly associated with a Fight or Flight response from the amygdala.

Thus creating a painful memory which may then serve as an emotional template or map for all related and interconnected experiences and events. This emotional template then forms the emotional set for the individual for these experiences and events.

With the use of the “K-Protocol” in IEMT, it is possible to clear these negative emotional imprints.

“The K-Protocol” - also known as the `kinesthetic pattern` involves tracking a current negative emotion back to its imprinting experience and utilising the therapeutic action of eye movements to resolve the emotional loading associated with this event.

The simple form of the K-Protocol is used to resolve simple traumatic experiences with simple emotional loading. An example of this might be a simple dog phobia where the person recalls being bitten by a dog. The simple form does not require much calibration by the practitioner.

The complex form of the K-Protocol is utilised where the events were more confusing and the emotional consequences are more complicated. An example of this might be abuse in childhood. The complex form requires a high level of calibration by the practitioner in order to achieve desirable results.

Identity Imprints

Identity imprinting occurs throughout life and is constantly evolving and changing. Some aspects of identity are attributed neurologically but mostly occur 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. Some people will be able to adapt with the appropriate emotional and behavioural adjustments better than others who may find themselves in conflict with themselves.

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 is a behavioural pattern that serves to defend the problem from therapeutic change. These patterns can be readily discovered through simple linguistic analysis of the ways in which the client expresses him/her self.

Whilst a 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. As a result, the patterns of chronicity allow the client to 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 key patterns of chronicity:

1. The Three-Stage Overreaction.
2. The Maybe Man.
3. The Great 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

[Formerly known as the “3 Stage Abreaction” or “3SAR”] This is a pattern resulting from the conviction of some clients that the therapist (and others) should act according to their expectations. When a client experiences an undesirable emotion, he/she may try to transfer the responsibility for that undesirable emotion onto the therapist and expected from him to make changes to the process. This attitude of the client often results in three distinct stages leading to “punishing” the therapist (or others) who does not obey the signal (see below).

The Three-Stages

Stage 1. Signal (Warning)

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 of 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*."

Also commonly expressed is responsibility for the negative emotion, such as:

“Your tone of voice is annoying to me.” “You are making me very uncomfortable.” “I don't like the way you are looking at me.”

Stage 2. Signal Amplification (Threat)

The second stage often involves a direct threat and takes the form of firm opposition, usually through emotional blackmail. A visible increase in negative emotion can often be seen.

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, hysterical crying, etc.

The Maybe Man

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 characterised 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... something like five or six out of ten.”

Linguistic modifiers are commonly employed, such as, “I kind of, sort of, maybe feel X,” “Well, I might say that I get angry”, “I don't know, maybe it is just I get angry, or something” etc.

The Great 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, solution or generalisation. The question is a trap.

Usually, the person asking this type of question has a ready answer, which he or she does 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.

So, “What if X is true, then B will also be true.” However, this is actually a *complex equivalency* where the speaker holds the value that condition X is actually *equal* to condition Y.

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 therapy by measuring the remainder of the problem rather than noticing the change being introduced.

These are individuals who in their observations will overlook a 99% improvement and focus on 1 per cent of the remaining problem.

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).

Post Traumatic Stress Disorder (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 that are common to PTSD are frequently resolved.

Physiological State Accessing Cues (PSACs)

Physiological State Accessing Cues is known in IEMT as PSAC’s for short.

It has been seen that when a person experiences trauma one of the physiological responses that can occur is a frozen 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.

Not everybody locking into a particular physiological state will have experienced what is traditionally know as a ‘trauma’, however 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 person's nervous system can become primed to react to cues based on past traumatic experiences that may not fit with a current situation.

The IEMT Practitioner is 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 very subtle.

The IEMT Practitioner can make use of the Subjective Unit of Distress (SUD) scale to ascertain what level of discomfort that person is currently at as they enter into a physiological response. By making the person aware consciously of the way that they are holding their body the IEMT practitioner can elicit small shifts in that physiology and ask the person very simply how this changes the subjective distress.

Through these processes, the practitioner is able to demonstrate to a person the relationship between their physiology and emotional state, and then with the subtle change in that physiology, there can be a tangible shift. This can often be a significant moment of insight for some people to understand that if they want to stop or downgrade the strength of a particular feeling or state all they have to do at that moment is a subtle physiological shift.

Such changes using the PSAC’s model is not necessarily creating longterm neurological change in the moment, however over time if a person becomes more aware of how their body can affect their mind they can start to exercise such changes more regularly and thus begin to repattern their emotional perception.

These principles can be utilised to incapacitate unconscious access into negative states. One method

for doing this is to use humorous shock and provocation to anchor a conscious taboo to the first physiological access cues by which the person accesses the negative state.

Psoriasis

One of the more unusual applications of IEMT has been in the treatment of psoriasis.

Psoriasis is a non-contagious dermatological disease affecting around 2% of the population. Studies reveal that psoriasis is mostly related to stressful life events, body mass index growth, smoking, alcohol use, skin infection, and the use of beta-blockers and other anti-hypertensive drugs.

Although psoriasis is primarily treated through means of prescription medication, psychotherapeutic approaches have also become more frequent as a secondary or complementary approach, especially in reducing the emotional stressful disorders associated with psoriasis. A case study in 2016 published in *Journal of Experiential Psychotherapy, vol. 21, no 3 (83) September 2018* shows promising results in treating psoriasis. Another surprising positive side-effect was the lack of client's additional epileptic seizures which have not reoccurred since the IEMT based treatment session.

The full case study is published here: https://jep.ro/images/pdf/cuprins_reviste/83_art_7.pdf

Controversies

On 18th June 2020, Michael Carroll posted via the John Grinder Facebook page (*all spelling, grammar, and punctuation as per original posting*):

> Ever wondered about EMDR and its spin offs? Here is what John Grinder wrote on the Whispering in the Wind forum re EMDR and its real origins.
>
> "Francine Shapiro worked (administration and sales) in the Santa Cruz offices of Grinder, Delozier and Associates in the 80's. She approached me (John Grinder) one day and told me that a friend of hers from New York has been raped and she wanted to help her through this trauma and ensure that she exited cleanly and without scars. I told Francine to systematically move her eyes through the various accessing positions typical of the major representational systems (with the exception of the kinesthetic access). I suggested that she see, hear (but not feel) the events in question - obviously the kinesthetics were to remain resourceful (the anchored state) while she processed the event.
>
> Francine later reported that the work had been successful. You may imagine my surprise when I later learned that she had apparently turned these suggestions into a format she called EMDR presented in an extended training, with no reference to source, with her own claim of copyright and a rather rigorous set of documents essentially restricting

anyone trained in this from offering it to the rest of the world.” [John Grinder]

EMDR and its subsequent copies came from NLP and directly from John Grinder, who is never referenced as the source in the new therapies, which are not new, just renamed! :(

People have been renaming EMDR through the years dipping into a scrabble bag of letters coming up with new acronyms to describe an old process, one that came right from John Grinder. This field needs a good clean up.

A question posted to John Grinder asking which part of IEMT matches this description has never been answered.