

Eye Movement Integration Therapy:

An introduction to the treatment of traumatic and distressing memories

by Danie Beaulieu, PhD

When a client's current problems are deeply rooted in memories of distressing experience, retrieving and expressing those memories is often an arduous and painful task. Treating the related problems becomes a challenge that NLP and psychotherapy methods generally fail to meet satisfactorily. Most therapeutic processes simply don't possess enough depth and power to reach the sources of the client's torment. I had been looking for truly effective and rapid treatments to offer such clients for some time when I first learned about Eye Movement Integration Therapy, or EMI.

EMI is a therapeutic approach radically different from any other I knew of at the time. It uses guided eye movements to assist a client to access recorded information in all its multisensory, cognitive and emotional forms. EMI recruits these resources to the *integration* and resolution of distressing experiences and their problematic psychological consequences. The impressive efficacy and rapidity of EMI derives from its ability to help the mind do precisely what it was designed to do: heal itself using its own inner resources.

One of my clients, for example, was troubled by nightmares and intrusive, fragmentary memories from his childhood with a violent father. Although Serge was functional, the irrepressible stress reactions induced by these memories drained his energy and left him in a state of near-constant anxiety. We began treatment with Serge focusing on the emotionally charged early memory of his father beating the family dog. I led Serge through a series of guided eye movements, beginning with calm, steady horizontal movements from one extreme to another of his visual range. Each set of eye movements was followed by a pause to let Serge reveal the new material that he had contacted in the sensory, cognitive and emotional modes. Gradually, I worked through the entire series of segments and patterns (see sidebar for details of the movements), choosing the sequence according to the intensity of Serge's reactions.

As we proceeded, Serge vividly recalled a series of details from the incident, some of which he had never consciously recalled before: the cries of the dog in pain, and the blood on the dog's skin and on the walking stick. In additional segments he relived begging his father not to hit the dog, not to kill the dog; he saw again the hatred in his father's face; and felt again the child's sadness, rage and helplessness, the pain in his chest and the weakness in his legs. Using the eye movements and the brief pauses, we eventually explored not only Serge's memory of his father beating the dog, but also associated memories of the father's abuse of his wife, and eventually, of Serge himself.

As the treatment advanced, it became clear that Serge was contacting not only painfully detailed recollections, but also experiences, insights and perspectives from other aspects of his life, gradually integrating his fragmented childhood memories with a wider, healthier context. When we eventually reached the point when no new information was being revealed with additional eye movements, Serge realized that the systematic violence meted out by his father was neither judgment nor punishment, but rather a symptom of his father's problems with alcohol and anger control. He felt relieved of the physical and emotional sensations of shame and fear

that he had carried for years. Rather than feeling terrorized that his father might still have power over him, he now regretted that he had never experienced having a good father, while also recognizing that he had nonetheless become a mature, understanding and competent adult.

Origins and modifications

This natural, eye-movement-assisted process of integrating painful memories into the greater context of the individual's life experience is the essence of EMI. I was introduced to this amazing therapeutic approach when Steve Andreas gave a workshop on EMI at the Conference on Ericksonian Approaches to Brief Therapy in Orlando, Florida, in 1993. Steve and his wife Connirae Andreas had developed EMI several years earlier, yet one more of many methods they have offered the NLP community during their exemplary careers.

Many readers will recognize that one of the tenets of NLP is that our spontaneous eye movements reflect our thought patterns and, in particular, that the direction of each eye movement is related to the sensory content of the thought or memory. Classically, for example, gazing upward and to the left is associated with remembered visual images, while gazing downward and to the right is associated with kinesthetic feelings such as emotions, touch, visceral sensations, and muscle movement.

The Andreases supposed that if thoughts could influence the direction of eye movements, perhaps deliberate eye movements could influence the content of thoughts. After testing the hypothesis with a few volunteers, Steve and Connirae realized that the technique had the potential to help people change the way they perceived problematic situations in their lives. Eventually, they began applying the technique as a treatment for traumatic memories and fears about future situations.

When I learned the EMI method in 1993, it was presented in a 45-minute discussion and a 45-minute demonstration with a volunteer who had suffered symptoms of posttraumatic stress disorder (PTSD) since his service in Vietnam. The effects were dramatic and convincing: after the treatment the volunteer had radically and positively changed his perception of an especially disturbing memory of an attack in which a friend had died.

The only problem was that, although I was persuaded that this approach worked, I didn't understand how. Unlike many members of the audience, I wasn't trained in NLP at that time. Tentatively, however, I began applying the EMI method with willing clients who had suffered traumatic events and were having difficulty recovering. Sometimes it worked like a charm, just as it had in Steve's demonstration. Unfortunately, sometimes my clients had reactions that I could not predict or understand, and I had to use all my resources and experience to salvage a good outcome.

Since that time, I've been adding to my understanding of EMI and its underlying principles. I studied NLP and another eye-movement-based therapy, Eye Movement Desensitization and Reprocessing (EMDR), developed by Francine Shapiro. I studied the scientific literature on the neurobiology of eye movements, thought patterns, memory, and trauma, seeking to understand the biological and psychological mechanisms that might lie behind EMI's astonishing efficacy. I added a much more in-depth pretreatment work-up, and a more analytical understanding of how memories function. I blended in more NLP anchoring techniques to help clients deal with emotional distress during and between sessions. And I made sure to

follow up after treatment with every client, to ensure that resolution had been truly complete and enduring.

The neurobiology of distressing experience

In order to understand how EMI works, we have to understand how memories are formed. In ordinary circumstances, sensory information is funneled from the sense organs to the thalamus, and from there the information is shunted to the various specialist parts of the brain: the occipital lobe for visual information, the temporal lobe for auditory and verbal information, and the frontal lobe, where the information is processed and integrated with stored knowledge to form a perception. Signals from the frontal lobe are sent back down to the limbic region, and the amygdala, where emotional associations are attached to the perception: pleasure, distaste, etc. Short-term recall and long-term consolidation of memories depend on the hippocampus, which has connections with all these parts of the brain and orchestrates the activation of all the bits of sensory, cognitive and affective information that compose a given integrated memory.

Distressing experience affects the mind differently than ordinary experience does. In threatening or intense situations, an alternative “emergency” pathway is invoked. Information from the thalamus can be sent directly—via a single synapse—to the amygdala, part of the primitive reptilian part of the human brain, which initiates survival behaviors and emotional responses a split second before the information can reach the more distant frontal lobe and form a clear perception. Essentially, nature has designed a shortcut to permit quick reactions in the face of a sudden threat, based on a “quick and dirty” reading of the sensory information by the amygdala.

If the amygdala perceives a threat message in the unprocessed sensory information, it sends out signals to the brain and endocrine organs to initiate the “fight or flight” response. It shuts down non-essential functions and triggers a jolt of adrenaline that tenses the muscles, sets the heart racing, quickens respiration and in general readies the body to deal with whatever terrible thing is about to happen. If it later turns out that the sinuous object on the forest path was not a snake but just a curved stick, the frontal lobe will send out signals that permit the body to relax, climb down out of the tree it had jumped into, and eventually let the heart beat and breathing return to a normal rhythm.

The central roles of the hippocampus and the amygdala usually work hand in hand. Moderately elevated activity in the amygdala causes improved connectivity of the hippocampus, and heightened potential for learning. Excessive stimulation of the amygdala by overwhelming experience, however, causes impaired hippocampal functioning due to the intensity of the neuroendocrine stress responses. This means that the hippocampus may not be able to coordinate the sensory and emotional information received during a crisis into integrated memories. The end result is that traumatic memories are often recorded as fragmentary, nonintegrated bits and pieces. The conversion of these nonintegrated memories into integrated form is thought by many psychologists to be essential for recovery from the psychological impact of the traumatic event.

Like Serge, in the case mentioned above, many clients have had key experiences in their lives that have left enduring imprints in their multisensory memory networks. Not all survivors of abuse, trauma or other distressing episodes will have trouble integrating the memory, but for many the traces remain paradoxically strong and fragmented simultaneously. In the most severe

cases, traumatic memories can contribute to severe mental disturbances such as dissociative disorder or posttraumatic stress disorder. In milder cases, anxiety or depression may be the only sign. The spectrum of symptoms that may stem from unresolved memories of distressing events also includes nightmares, flashbacks, emotional numbing, avoidance behaviors and panic attacks. EMI is useful for treating any constellation of symptoms or difficulties that can be reasonably traced to a traumatizing incident or period of the client's life.

EMI seems to be able to facilitate access to these troubling, nonintegrated memories, by circumventing the routine patterns of thought and avoidance that the client has habitually followed. Figuratively speaking, the eye movements appear to redirect the client's mind into dusty corners that have been neglected, releasing information—whether painful or healing—that can then be naturally incorporated into a new, healthful perspective on their current life and their past experience. It is almost as if EMI activates an inner homeostatic guide that leads the client out of the maze of their troubling memories. The varying patterns of eye movements, the reassuring environment of the therapist's office, the focus on the sensory, cognitive and affective aspects of the memory—all of these ingredients combine to produce an astonishingly effective intervention.

The treatment, in brief

After extensive experience with my clients, and years of teaching the now substantially modified EMI to my colleagues in Quebec, I understood enough about how EMI worked to write a book about it, with the kind permission of the Andreases. Although this article can only scratch the surface of what is presented in detail in the book, awareness of its existence will, I hope, help other therapists help their clients overcome the effects of traumatic and distressing experiences. Even the book is insufficient to really master EMI: it is such an experiential therapy that it is essential to participate in workshops or supervised practice that provides the opportunity to experience the effects of guided eye movements. Briefly, however, I would like to sketch out how the treatment is conducted, with the caveat that this information is wholly inadequate to substitute for training.

Before beginning treatment with EMI, I recommend that the therapist conduct of full client work-up. Devote a session to exploring the reasons the client has sought help, his family and social environment, and his physical and psychological condition. Explore the coping strategies that the client has been relying on to deal with his current problems, as well as those he has used routinely in the past. All of this information will help the therapist recognize potential problems before they arise, and avert difficulties during the future sessions.

During the work-up, begin to develop an understanding of the structure of the client's troubling memories. Was there a single, overwhelming event or a series of repetitive traumas? Are the memories clear, sequential, eidetic recollections, or vague, hazy, disjointed fragments? What emotions are associated with the memories? What are the associated cognitions? What consequences do these distressing memories have in the client's current life? It is not necessary to delve into the details of all the client's memories—the EMI treatment will allow them to be revealed when and if they become relevant—but it is very useful to have a good grasp of the scope and architecture of the problem.

Once the nature of the distressing memory is identified, the therapist can map the clients

visual range by moving his hand, with the first two fingers extended, to the limits that the client can comfortably follow with his eyes, without moving his head. At the same time, the therapist can explore the areas or “quadrants” of the visual range that are more and less emotionally comfortable for the client. Very often, a certain quadrant will be associated more strongly with negative emotions related to the trauma; for example, gazing to the lower left might bring back intense memories of a near-drowning incident. Likewise, it is a good idea to determine which quadrant allows the client to contact positive feelings, and to create an anchoring link to that state when his eyes are directed into that quadrant.

The treatment is begun with the client concentrating on a particular memory that appears to be central to his experience: a highly emotionally-charged episode, as in the case of Serge; or the earliest memory of a repeated trauma; or the first scene in a sequence of recollections of a single distressing event. The guided eye movements are begun by moving the hand, with two fingers extended or holding a bright marker, at a distance and rhythm that the client is comfortable following; the client should always feel that he is in complete control of how the movements are done. We often start the treatment using an eye movement that connects quadrants previously identified as relatively untroubled for the client, so that painful material is not contacted too abruptly and the client has time to adjust to the procedure.

After five or ten back-and-forth movements, the hand is softly pulled back toward the therapist’s body, and the client is asked an open-ended question, such as, “What’s there now?” or “What do you have?”, allowing the client to describe what is happening during the eye movements in her own fashion. The client is encouraged to describe her experience in at least three modalities or submodalities. We avoid distracting her from her own description, but when she has finished we inquire further, “Are there images? Physical sensations? Emotions?”

These three dimensions—visual, kinesthetic, and affective—are often the principal modes in which the re-experience of traumatic memory occurs. However, we could also ask about sounds, smells, tastes, thoughts, following the client’s lead, but consistently trying to elicit information in at least three dimensions.

Each therapeutic session should conclude only after completing all of the eye-movement patterns at least once and assuring that the client has reached a tolerable emotional plateau. Because it is not possible to accomplish this within the sixty minutes of a typical therapy session, we try to schedule 90- to 120-minute sessions for EMI. Often, complete resolution of problems related to a single traumatic event can be achieved in one session, and the most complex cases I have seen were successfully treated with a total of only six or seven sessions. When planning treatment, then, it is best to attempt to estimate how complex the problem is, and perhaps to break it down into elements that can be treated in a single 90-minute period.

In the case of Serge, for example, there were so many separate events involving his father’s violence that we agreed to only work on the incident with the dog for the first session. The treatment proceeded so well that we continued working through a couple of associated memories, but stopped the first session before working on the memory of Serge being beaten by his father. I made sure that Serge had reached a place of calm and was no longer reacting strongly to his memories before we ended the first session, and took up the remaining nonintegrated memory a week later. In that second session we were able to complete treatment of his troubling memories and the associated current problems, as described above.

Follow-up is always required, even for clients who seem to have resolved their difficulties

in a single treatment session. The enhanced access to distressing memories that is catalyzed by the eye movements and the linkages that begin to form between newly contacted information continue for several days following EMI treatment. Many clients will report increased dream activity, or surprising, illuminating insights, or dramatically altered behavior in the days and weeks that follow an EMI treatment. A follow-up session permits the therapist to assure that no problematic memory circuits remain to be treated, and that the outcomes and repercussions of treatment are beneficial for the client.

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My enthusiasm for EMI is based not only on my own experience, but also on that of the many clinicians, psychologists and social workers whom I have trained in the last ten years. Many have told me amazing anecdotes of the transforming effects EMI has had for their clients. Together, we conducted a small pilot study and found that, on average, a single treatment with EMI could reduce post-traumatic stress symptoms by 48%, while a full course of treatment reduced symptoms by 83%. These results are confirmed every time a client troubled by unresolved distressing memories seeks help from a skilled EMI practitioner. Releasing them from the burden of the traumatic baggage they have carried for years never ceases to be one of my greatest professional rewards.

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