Eye Movement Integration Therapy

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THE COMPREHENSIVE CLINICAL GUIDE

Danie Beaulieu, PhD

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Chapter One

The Origin of EMI

Introduction

Marc was referred to me about five years after prison inmates took one guard and three other prisoners hostage at the maximum-security penitentiary where Marc was a guard on the crisis-management team. The hostages had been tortured savagely during the long negotiations before the gymnasium, in which the hostage takers had barricaded themselves with their victims, was finally forced open. Marc was the first guard on the scene, and the first to confront the horrifying vision of the mutilated corpses of the three hostage prisoners and the appalling wounds of the guard, Jean. Marc's friend and co-worker lay with burns covering every exposed inch of skin, the result of torture with cigarettes and lighters. Later, Marc was to recall most distinctly the intense concentration of energy that was required to deal with the psychopathic inmates, the long minutes as he carried Jean in his arms to the infirmary, and the clean-up of the pieces of brain tissue and smears of blood from the walls and floor of the gymnasium.

When I met him, Marc had not been able to work for the past three years, disabled by a tremor in his right arm that had developed progressively as he attempted to maintain his self-appointed role of protector of his fellow guards—helping them recover from the trauma of the hostage incident and continuing to be the first to take action whenever there was trouble. He had been examined by a neurologist and told that the tremor was a permanent condition for which no treatment was offered. The tremor worsened whenever a conversation with old colleagues or the sight of passing prison trucks reminded him of the hostage crisis.

Even without the shaking in his arm, it is doubtful that Marc could have held a job at that point: he was suffering severe symptoms of posttraumatic stress that several attempts at psychotherapy had

been unable to improve. He was plagued by frequent nightmares, paralyzing flashbacks, outbursts of rage, and fits of depression. He had become sexually impotent, violent toward his wife, completely impatient with the slightest provocation. Marc reacted most strongly to the sight of men with tattoos or men who, according to his view, "looked like criminals". As his symptoms worsened, he had self-medicated his pain with alcohol and drugs, and eventually spent many weeks in a psychiatric ward for treatment of his suicidal tendencies. By the time I saw him, it was clear that he held out no great hope that yet another psychologist with yet another new form of therapy would be able to help him.

In our first session, we discussed Marc's background, the nature of his current difficulties, the effects of his problems on his family and social life. I explained to him how Eye Movement Integration works, and the type of reactions he might experience, and he agreed to return the following week for the first treatment. During that second session we began EMI with Marc focusing on his most intense memory—the first impression he had when he broke through the gymnasium door and saw the devastation. For ten seconds or so, Marc's eyes tracked the movement of my hand, leading him in a series of horizontal, vertical, and diagonal patterns, while he concentrated on his memory. After each segment of eye movements, we paused briefly, and Marc told me what was in his mind.

During sequential eye movements, Marc revived many associated impressions of terrifying and appalling situations at the prison, and the fury he felt toward the inmates who were capable of such brutality. However, as he continued to track my hand movements with his eyes while thinking about Jean, for the first time his thoughts contained elements of emotional satisfaction. Letting go of his entrenched belief that it was all his fault, that he should have taken action earlier, he was able to realize that it was the psychopathic prisoners who were the source of the horror, that he had done everything he could, and that Jean had been placed in good hands. Although it was emotionally wrenching at times, by the end of an hour and a half of integration, Marc felt real relief. Immediately after the integration, as we were reviewing the results together, he looked down at his hands—which were not trembling now—and exclaimed, "Hey! I won the lottery!"

In the weeks following the first treatment, Marc's sexual potency returned, and he began to feel more in command of his reactions. Although the trembling in his right hand occasionally returned, it was no longer uncontrollable. He began to perceive the tremor as a signal that he should switch his attention away from his experiences at the prison. Not surprisingly, though, certain aspects of the experience still caused him pain, and when he returned for the third session we chose to work on the most pressing remaining problem.

One of the triggers of his outbursts of fury seemed to be the particular yellow-green color of his little girl's plastic scissors. At the mere sight of them, Marc would fly into a wild, inarticulate rage. After such outbursts he was devastated and exhausted, barely able to stand, and would spend most of the remainder of the day lying down on the couch. Beginning with that situation in mind and following a few eye movements, Marc suddenly recalled that the color of Jean's burned skin was the same vivid yellow-green as the scissors. Although some progress had been made in the previous session, a strong visual association persisted. Subsequently, when I asked him to picture a good memory of the yellow-green color, he mentioned that, when he was young, his mother had hung some cheerful yellow-green floral curtains in the kitchen. When asked to hold both images in his mind—the original scene where he found his friend covered with yellowed burns and the picture of the kitchen curtains—Marc was astonished at the image that suddenly sprang to mind: he saw his friend Jean, lying comfortably in a garden of yellow flowers, with a wide smile on his face. In the next segment of eye movements, Jean was waving goodbye as he drove off, still smiling. Marc felt an unburdened lightness at the conclusion of that day's work, and had no further problems with his daughter's plastic scissors.

A total of six treatments were needed to overcome the entirety of Marc's original trauma. At one defining point toward the end of the integration, he saw himself walking out of the prison, waving goodbye, as if it was all over. Previously potent triggering stimuli had lost the power to provoke flashbacks or anger, and Marc was able to perceive "criminal" types more objectively and calmly. The trembling in his hand had become almost nonexistent as fewer and fewer situations triggered distress. Today, Marc is employed

Chapter Two

The Application of EMI

Treatment of Traumatic Memories and their Consequences

Introduction

In the years since its development, EMI has proven its efficacy as a treatment for clients with a wide range of presenting problems, from incapacitating post-traumatic stress disorder (PTSD) to difficulties at work, from severe depression to sexual dysfunction. These diverse clients share one common denominator for their current problems: they are plagued by disturbing memories of some past event that persistently intrude on the present, undermining the client's ability to function and to enjoy life in the present, and to look forward with anticipation to the future. Put simply, EMI is an effective treatment for *all distressing and recurrent memories* that create negative impacts in any sphere of a person's life, regardless of how they manifest their adverse influence.

In this chapter we will offer a functional definition of trauma and explore the distinguishing features of traumatic memory, including research on the nature of traumatic events and the circumstances that place individuals at greater risk of developing subsequent problems. We will examine the consequences and costs of traumatic memory in all the dimensions of the victim's life and how we approach these problems as psychotherapists. Finally, we will describe how EMI permits resolution of disturbing memories, even in cases where traditional therapies have failed.

I. The causes of psychological trauma

Defining trauma and traumatic stress

The spectrum of psychological impacts of events

Every event we experience—whether positive or negative—will have repercussions according to the idiosyncratic constitution of the individual; the learning and behavior changes that occur as a result of experience can be useful or damaging depending on the myriad details of personal circumstance. As therapists we may have a tendency to focus exclusively on narrowly defined psychological trauma, but in fact every experience leaves some imprint or trace that adds to the internal world of the individual, and influences them in some way. Faced with a vastly diverse clientele, whose experiences are always particular and personal, it is vital that we define psychological trauma in terms that will rationally guide our treatment approach.

Consider, for example, the case of a fearful, compulsive client who seeks assistance in overcoming her difficulties functioning at her job. The only adverse experiences the client can identify during the assessment interview are her mother's frequent, caustic and denigrating remarks, which went on for years during the client's childhood and persist even now when she has children of her own. The client had little support as a child to counterbalance or neutralize the effects of these remarks, and gradually developed a tendency to dramatize her situation, thus recruiting some measure of support and caring from others. Now an adult, she exhibits an extreme lack of confidence, a paralyzing timidity, and a compulsive attention to routine and order. Do we call her damaging childhood a traumatic event and its aftereffects PTSD? Probably not, because the severity of the acts themselves is minimal relative to other events, and the client certainly does not meet all the criteria for a PTSD diagnosis. Yet the duration and frequency of the comments, the poor self-image, and absence of social support for the child all contribute to the negative impact caused by such experiences. Did these early events affect the client's current functioning, in clearly negative ways? Definitely yes, as there is at least a probable link between her fearful and compulsive behavior and her childhood experience. In this case a mother's ceaseless scolding resulted in psychological trauma, even though for another person

in other circumstances this might have been merely one sad aspect of an otherwise pleasant childhood.

Thus, at one end of the spectrum of impacts of life events there is certainly PTSD, but we could also define a new, less severe syndrome: the Post-Negative-Event Effect, or PNEE, which might apply in the case presented above. At the other end of the spectrum we find the PPEE (Post-Positive-Event Effect). In between, we might identify the more moderate syndromes such as the PBEE (Post-Boring-Event Effect), the PFEE (Post-Funny-Event Effect) and so on. Each of these "effects" is a neural record of the event and the associated affect, sensations and linkages to other memories. Each is able to create some form of re-experience: arousal or tranquilization, avoidance or attraction to a stimulus, feelings of sadness or wellbeing, fear or joy.

The manifestation of each "syndrome" depends on the unique experience of the individual. PPEE might manifest as the behaviors and symptoms elicited by a wonderful experience like winning the lottery. While some winners respond with understandable happiness and make reasonable changes in their lives, others keep playing the lottery, or increase how much they spend on it, long after their winnings are exhausted, in what is clearly an unhealthy response to a good experience. PBEE might be manifested as avoidance of your next-door neighbor after a particularly soporific conversation at a backyard barbecue, or skipping the lectures read in a listless monotone by your least-favorite university professor. Much of our behavior and psychological health is determined by the accumulation of life experience and our responses to it. In simplified cartoon fashion, we can regard the psychophysiology of our brains as a bank account. Positive events are deposits while negative events result in withdrawals. The account balance depends on the totality of our experience.

These suggestions of new "syndromes" are made with tongue in cheek, of course, and are not intended to demonstrate any disrespect for sufferers of PTSD. The point is simply that every experience creates a ripple effect in our lives, influencing us in profound or insignificant ways in the present and future. When those influences are strongly negative and limiting; when they disturb our functioning; when they deny us full enjoyment of life; when they

Chapter Six

Discovering the Memory Network

Introduction

The objective of the EMI approach is to recruit the inner resources needed to resolve a painful memory. Our choice of a specific problematic memory from among all the traces recorded in the mind will greatly influence the efficiency with which we are able to accomplish this goal. In this chapter we will first discuss the criteria we apply in choosing the initial target memory for EMI work. This is followed by a conceptual exploration of the structure of memory networks and the implications that these patterns have for planning treatment. Finally, we will describe the multidimensional inner representation of memories.

I. Selecting the starting memory

The integration process of EMI begins with the identification of a memory that is troubling to the client. Our selection of the initial targeted memory is critical to the efficient assimilation of the toxic content of the memory network into an ecological balance with the life experience of the client. It can be surprisingly complicated to choose a single starting memory, because the client will often have many recollected scenes, partial memories, or related events that all make up part of her painful experience. This section will provide some guidance for how we can best identify the appropriate, central memory with which to begin EMI.

Sometimes, the choice of base memory is very clear for both the client and the therapist. Someone who was in a car accident, whose mind is frequently taken over by thoughts of being trapped behind the steering wheel of her car, waiting for the firemen to extricate

her with the "jaws of life", will have no difficulty in clearly identifying the target for EMI work. Most of the time, however, either the client's painful experience was repeated many times (as is often the case with cases of childhood sexual or physical abuse), or there are many strong memories or sequences of memories related to the same trauma. The choice among all of this recorded material is not necessarily simple, but it can always be done.

Even for what might seem to be a single defined event—being present during a bank robbery, for example—the traumatic-memory network may be made up of a series of highlighted combinations of images, sounds, or other sensory or emotional recordings. In the case just mentioned, the client might recall the sinking sense of fear and surprise when the thieves walked into the bank with their weapons. The image of the thieves walking is itself a fragment of the recorded event. The client might also recall the yelling of the bank customers; her heart racing when one of the robbers grabbed her as a hostage; the horror of the thought of imminent death; the consequences of her death for her children; the pity she felt for a screaming bank clerk.

In still other cases, the memories are vague and uncertain, leaving the client with only a few bits of information, isolated in one or two sensory systems: a blurry blue color somehow connected to an overwhelming but nebulous anxiety, or a haunting, indefinable pain from a phantom limb. This section will help the therapist to find the clues that will identify the most effective starting point, when initially it may not be clear at all. All of the skills and experience of the clinician will be useful during these evaluation and preparatory steps, as well as during EMI itself. The training, wisdom, intuition, and judgment developed with other forms of psychotherapy should sustain the therapist, just as the new principles unique to EMI should inform and guide him.

Intensity matters

Many situations that create negative long-term emotional effects continue for years. Conjugal violence, prolonged illness, childhood abuse, extreme poverty and subsequent social repercussions, suicidal tendencies in parents—all of these situations share a pro-

tracted or repetitive pattern, making it difficult for the client to identify a single, central memory. However, if we examine the various memory fragments for intensity, usually one memory will stand out that generates the strongest emotional response or that is the most intrusive. Often, the same memory will be both the most emotional and the most intrusive. These most intense memories are good candidates as starting targets for EMI.

There are occasions when the client has many distressing memories all related to the same ongoing situation, all apparently with the same intense emotional charge. In these cases, we usually will begin at the beginning, i.e. with the first remembered moment of high-intensity distress. This choice is guided by recognizing the reality that this is where the negative imprints began, and all subsequent memories built on these initial impressions. The client will tend to return to these original scenes during EMI processing even if we begin at a later point, so going directly to the source follows their internal logic as well. In the case of a woman who was repeatedly sexually abused by her uncle, from the time she was five years old until her uncle died, when she was eleven, many separate incidents were remembered with similar intensity. The memory of the single occasion when her uncle assaulted her in the barn elicited vehement disgust and loathing, but the repeated abuse that occurred in the basement of her home brought back the terrible fear with equal force. Helplessness was the dominant emotion when she recalled the abuse that took place in her uncle's bedroom, where her cousins also participated in the sexual acts. Given the comparable strength of each separate memory, the integration process was started with the oldest recollection in this grim repertoire. Subsequent events were contacted in a natural, chronological progression, until full resolution was achieved.

The advice in the preceding paragraph holds equally well for those clients who experienced only one traumatic event, but whose memory networks consist of many distinct images or fragments. If at all possible, we identify the most intense image, with the highest emotional charge. Otherwise, there may be one image or fragment that the client feels is the "index" image. The victim of a single-car accident, for example, recalled a series of images, associated thoughts, and emotions. As her car started sliding on the ice, part way down a long slope, she realized that she had lost

Danie Beaulieu is one of the most lively, innovative and intelligent teachers of psychotherapy that I have ever encountered. *Eye Movement Integration Therapy* is just one of her many valuable contributions. This rising star is sure to impact our field and impact our effectiveness as clinicians.

Jeffrey K. Zeig, PhD, Director, The Milton H. Erickson Foundation

Danie Beaulieu presents for the first time a thorough review of the theory and application of Eye Movement Integration, a therapeutic approach to the resolution of trauma and anxiety based on NLP's eye-movement accessing cues. From the evidence presented, it is clear that Eye Movement Integration Therapy should be seen as a serious contender to the throne currently occupied by EMDR.

Peter Mabbutt FBSCH, FBAMH,
Director of Studies, London College of Clinical Hypnosis

This is an amazing book about a clearly very powerful method. The subject of Eye Movement Integration is tackled with great clarity and in great depth. An impressive read, and one that I am sure will be an asset to anyone who wants to add an important tool to alleviating their clients' problems.

Vera Peiffer, BA(Psych), FAACT, MHS

Danie Beaulieu has done an exceptionally thorough job of researching and documenting our original fascinating and powerful technique, to make it possible for others to learn how to use it safely and effectively.

Connirae and Steve Andreas, NLP developers, trainers, and authors

Dr. Beaulieu has written a splendid book. If you want an addition to your professional library that contains an excellent review of the latest neurophysiology regarding trauma and the brain written in understandable prose, and a splendid, coherent analysis of one of the newest therapeutic techniques for the psychotherapy of trauma-spectrum disorders along with a clear description of how one actually uses the techniques, then this is the book you are looking for. I highly recommend it.

Marlene E. Hunter, MD, FCFP(C),
Past President, International Society for the Study of Dissociation and
Past National Co-Chair, Canadian Society for Studies in Trauma and Dissociation

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