An Introduction to Eye Movement Integration Therapy

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Abstract:
Eye Movement Integration Therapy (EMI) is an innovative treatment for the psychological consequences of distressing memories. It promotes healthful integration of the traumatic memory with counterbalancing, ameliorative information by using guided eye movements to facilitate access to the recorded multisensory and affective dimensions of the client's experience. It is a powerful method that appears to tap into the mind's natural ability to heal itself. This article presents the background, development and application of EMI, as well as the neurological aspects of traumatic memories. Consideration is also given to possible mechanisms that may contribute to the observed efficacy of this therapeutic approach.

Keywords:
Eye Movement Integration Therapy (EMI), Post Traumatic Stress Disorder (PTSD), Phobia, Panic Disorder, Anxiety, Bereavement, Psychosomatic Pain, Stress
In the history of psychotherapy, few problems have remained as great a challenge as the treatment of clients whose problems are rooted in memories of distressing experience. Although many people are able to recover from traumatic experiences without intervention and without long-term consequences, in some, trauma can create memories that are highly emotionally charged and fragmented and whose resolution requires treatment. Created in 1989 and continuously refined since then, Eye Movement Integration Therapy (EMI) offers one of the most effective and innovative therapeutic approaches for these clients. EMI taps into the natural healing processes of the mind that, for whatever reason, did not occur spontaneously in the client. It promotes rapid resolution of distressing experiences and their problematic psychological consequences by integrating the traumatic imprints with counterbalancing and ameliorating information from the client’s own resources. Metaphorically, traumatic memories are like chlorine: they are caustic and damaging in concentrated form. EMI allows that chlorine to be diluted with clear, healthful water in the form of healing information, rendering the traumatic memories harmless and even purifying, in the same way that chlorine added to a drinking water supply or a swimming pool is purifying.

As the name implies, EMI uses guided eye movements to facilitate this integration process. In simple terms, problematic traumatic memories have been isolated and sealed off from the sort of normal access we have to other forms of memory. They may intrude at unexpected moments as flashbacks or nightmares and induce behaviors such as avoidance of certain situations which may stimulate undesired recollection and induce other deleterious effects in the person’s daily life. People who have lived through trauma without developing this kind of difficulty have evidently resolved their memories in a more healthful way. EMI appears to tap into the natural mechanisms of the mind to integrate the trauma that is etched in memory with the healthful, beneficial memories of the client, placing the trauma in a different, more healthy perspective. The eye movements allow the client brief, deep contact with the multisensory content of both the traumatic memory and positive memory traces. The traumatic memory does not disappear, but its power to disrupt the client’s life and cause limitations in their functioning is abolished. Thus, EMI’s impressive efficacy derives from its ability to help the mind do precisely what it was designed to do: heal itself using its own inner resources.

This article will present a brief introduction to EMI, its origins and development, how an EMI therapy session is conducted, as well as possible mechanisms for its effects. The various types of problems that can be addressed with EMI will also be discussed, and a case illustrating its application will be presented. A single article cannot supply enough information to assure the correct application of a new therapy; my intention is to introduce this extremely efficacious method to a wider audience, in hopes that more therapists will begin to explore its potential. Additional training is highly recommended before attempting to use these methods with clients.

Origins and development

As stated above, EMI uses eye movements to allow the client to access memory traces and to integrate traumatic memories with ameliorating information. Eye movements and their correlation to thought processes have long been the subject of intense interest among NLP researchers. Robert Dilts and others showed that, in the absence of visual distractors, the direction of our eye movements is related to the sensory content of the thoughts or memories we are focusing on (Dilts, 1990). Classically, for example, gazing upward and to the left tends to be associated with remembered visual images, while gazing downward and to the right is related with kinesthetic feelings such as emotions, touch, visceral sensations, and muscle movement. These tendencies hold statistically for large populations, but each individual will have their own particular pattern of eye movements that are associated with different thought processes.

In the late 1980s, Steve and Conniare Andreas began to examine this relationship with an eye on its therapeutic potential (Andreas & Andreas, 1989). They 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, they 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. I learned the EMI method in 1993 in a workshop conducted by Steve Andreas, which included a demonstration with a volunteer who had suffered symptoms of PTSD since his service in Vietnam (Andreas, 1993). The effects were dramatic and convincing: after a 45-minute treatment the volunteer had radically and positively changed his perception of an especially disturbing memory of an attack in which a friend had died.

Since that time, I have worked, with encouragement from the Andreases, to develop EMI into a comprehensive therapeutic approach. I have added to my understanding of EMI and its underlying principles by extensive reading and practice. I studied NLP and another eye-movement-based therapy, Eye Movement Desensitization and Reprocessing (EMDR), developed by Francine Shapiro (Shapiro, 1995).

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 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 (Beaulieu, 2003). 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 a 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. Likewise, it is a good idea to determine which quadrant allows the client to contact positive feelings, so that the therapist can always rely on this location to modulate the intensity of the
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, 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, smoothly and rather slowly, 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 may want to 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. The eye movements that are normally used in an EMI session are illustrated in Figure 1.

After three or four 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 are you experiencing now?”, 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 sensory or affective modalities (visual, auditory, kinesthetic, gustatory or olfactory and emotions) or sub-modalities (color, intensity, loudness, hot/cold, rough/smooth, etc.). We avoid distracting the client from her own description, but when she has finished we inquire further, “Are there images? Physical sensations? Emotions?” in order to fully explore the dimensions of the experience.

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 always possible to accomplish this within the sixty minutes of a typical therapy session, we try to schedule 75- to 90-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 five or six 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.

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 client has the proper tool box to deal with the outcomes and repercussions of the treatment.

Applications

In the years since the development of EMI, it has been applied to a wide variety of clients and problems. In fact, the limits of its uses are still not known. Traumatic and disturbing memories can clearly be effectively treated by integration with counterbalancing information; however, any problem that involves a negative perception of a situation may similarly be susceptible to treatment with EMI.

EMI has successfully been used to treat clients struggling with phobias, panic disorder, anxiety, bereavement and even psychosomatic pain. We can view each of these problems as being a question of perspective. Phobias, for example, involve perceiving unthreatening situations as threatening, whereas extended or unhealthy grieving may involve perceiving the loss as insurmountable and life as no longer worth living. In these situations, EMI can assist the client to regain access to memories, emotions, physical states, and sensory and cognitive information that have remained isolated from their habitual, adapted thought patterns.
Pattern A: Segments A1, A2, and A3 are all horizontal, with A1 at the upper edge of the visual range, A2 at the level of the client’s eyes, and A3 at the lower edge of the visual range.

Pattern B: Segments B1, B2, and B3 are all vertical, with B1 at the left edge of the visual range, B2 oriented at the center of the client’s body and face, and B3 at the right edge of the visual range.

Pattern C: Segments C1 and C2 describe an "X" from the extreme corners of the visual range. Each diagonal line is used as a separate segment. However, if one of the diagonal segments is used, the next segment performed should be the alternate diagonal.

Pattern D: Segments D1, D2, D3, and D4 describe two "X"s, side by side, one in each half of the visual field, moving between the extreme borders. Again, the paired diagonals should be performed consecutively. Once an "X" is started, the next segment should complete it before moving on to another segment. However, the D3/D4 pair need not be performed immediately after the D1/D2 pair.

Pattern E: Segments E1, E2, E3, and E4 describe two "X"s, one above the other. E1 and E2 are done in the upper half of the visual field, moving to each extreme of the visual range. E3 and E4 are done in the lower half of the visual range. They should be performed as described for pattern D.

Pattern F: Segments F1, F2, F3, and F4 form a large diamond shape, moving between the top, side, bottom and other side of the visual range. Each segment may be performed separately, or, if the client desires, the four segments can be performed together as a single, diamond pattern. This pattern is reserved for use toward the end of integration.

Pattern G: This single-segment pattern follows a counter clockwise spiral from the outer edges of the visual range to the center, in steadily smaller circles, then spirals outward again, then inward, repeating as needed. This segment should always end with an inward spiral, finishing at the center of the visual field. This pattern is reserved for use toward the end of integration.

Pattern H: This single-segment pattern is performed as in Pattern G, but forms a clockwise spiral pattern. This pattern is reserved for use toward the end of integration.
Representative Session

One of my clients was troubled by nightmares and intrusive, fragmentary memories from his childhood with a violent father. Although Brian 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 Brian focusing on the emotionally charged early memory of his father beating the family dog. I led Brian 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 Brian reveal the new material that he had contacted in different modalities. Gradually, I worked through the entire series of segments and patterns, choosing the sequence according to the intensity of Brian’s reactions.

As we proceeded, Brian 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 Brian’s memory of his father beating the dog, but also associated memories of the father’s abuse of his wife, and eventually, in a subsequent session, of Brian himself.

As the treatment advanced, it became clear that Brian 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, Brian 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.

This case illustrates the interconnectedness of traumatic memories. Although the beating of the dog and the violence toward Brian’s mother and Brian himself all occurred on separate occasions, they were connected by the nature of the experience. Working on a single problem may lead to others that are related by the complex architecture of the memory networks. Reaching a completely ecological integration cannot be achieved without addressing all of the related material.

EMI and EMDR

In addition to having substantially contributed to the development of EMI over the last twelve years, I am trained in EMDR. These two therapies use eye movements, but there are a number of critical differences. EMI can offer added flexibility for therapists who use EMDR, due to its adaptability to the needs of the client and its emphasis on multisensory experience. In EMDR, one basic eye movement is used—a quite rapid, saccadic movement from side to side. It was only later in the development of EMDR that the option of using alternative directions of eye movement (only if the client is not progressing) or other types of stimuli (flashing lights, knee taps, etc.) was introduced. However, in practice, most EMDR clinicians tend to use the side-to-side eye movement.

EMI has a dramatically different emphasis, derived from its origins in NLP and its development as a multisensory intervention.

The premise of EMI, derived from observations of natural eye movements and their associated thoughts, is that all of the different quadrants of the visual field should be explored in order to facilitate contact with the entirety of the client’s relevant multisensory experience. Thus, we use a well-defined series of eye movements (horizontal, vertical, diagonal, circular) that connect each of the visual quadrants with all of the others in a systematic manner. Each of these eye movements facilitates contact with different aspects of the client’s recorded expe-
The EEM Movement Integration Therapy provides profound contact with the client’s disturbing memories when his gaze is directed in a particular direction, whereas positive material emerges from a completely different, but equally distinct quadrant. Similarly, visual information may emerge when we guide his eye movements in a particular way, and kinesthetic information will emerge with a different eye movement. Years of clinical experience, by hundreds of practitioners, has shown that contact with, and integration of all of this information—the negative and the positive, in all of their multisensory aspects—is the basis for the remarkable efficacy of EMI.

Another important facet of the EMI approach is the emphasis given to respecting the client’s needs and preferences. We posit that EMI acts by facilitating an essentially natural process of healthful integration of experience that has, for whatever reason, not occurred spontaneously for our clients. To be maximally effective, therefore, the process must be as “organic” as possible. The therapist adjusts the position of her hand so that the distance from the client’s eyes is completely comfortable—both physically and psychologically. Similarly, the speed, length, and direction of the guided movements are adjusted at the client’s request. One client may be comfortable with a fairly rapid movement, while another prefers a very slow, smooth rhythm. All of these parameters can be changed at any point in the therapy, to assure that there is nothing that causes an irritation, distraction or interruption of the client’s contact with his experience. In fact, throughout the treatment, EMI therapists will periodically ask the client if the way in which the movements are done is to his liking, and make any needed adjustments.

All of these variables—the direction, distance, speed, and length of the eye movements—give the therapist and the client enormous flexibility to fine-tune the process to the needs of a particular case. Every client is unique, as new EMI therapists rapidly discover. It is astonishing how a seemingly minor adjustment can result in a dramatic change in the client’s ability to make contact with his memories. The therapist can also modify any of these variables when she judges that a change will favor contact with or integration of certain elements. For example, moving her hand closer to the client can have the effect of “pushing” gently to help deepen contact, whereas moving slightly away may diminish the intensity of a particularly overwhelming emotional recollection.

This flexibility favors the development of a close therapeutic relationship, another key element in the efficacy of EMI. The therapist and client thus become a therapeutic team, working together to suss out the most pertinent information to bring resolution in each case. The client feels actively involved in his own healing and his sense of control over the process minimizes any resistance.

EMDR trainers warn new therapists about the possibility of “abreactions”—adverse, highly emotional reactions that can be frightening for both the client and the therapist. Therapists require great skill and training in psychology to handle these powerful reactions. EMI, in contrast, equips the therapist—and the client—with built-in “safe harbors” or anchorages: eye movements or specific visual quadrants to which they can have recourse when powerful emotional material threatens to overwhelm the process. The same intense experiences may be contacted, but the therapeutic team remains much more in control in EMI. Abreactions may still occur, but they normally do not interrupt the process or damage the therapeutic relationship.

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, fear, etc. Short-term recall and long-term consolidation of memories depend on the hippocampus, which has connections with all these parts of the brain.
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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. Work by Joseph LeDoux and others has demonstrated that survival reactions in the face of threatening or intense situations use an alternative “emergency” pathway (LeDoux, 1992). 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 trauma experts such as Bessel van der Kolk to be essential for recovery from the psychological impact of the traumatic event (Van der Kolk, McFarlane, and Weisaeth, 1996).

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 fragmentary simultaneously. In the most severe cases, traumatic memories can contribute to severe mental disturbances such as dissociative disorder or post traumatic 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 (Van der Kolk, McFarlane, and Weisaeth, 1996). 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 appears 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.

Eye movements and the mind
Although the treatment of many clients by many EMI therapists has convincingly demonstrated the excellent efficacy of this approach, the precise mechanisms underlying this effi-
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...cacy remain to be elucidated. The foundations of EMI in the NLP theories of associations between eye movements and thought processes are reasonable, but does not adequately explain what is happening at the neuronal level. However, several other lines of evidence point to the intricate interplay between eye movements and thoughts.

It has long been known that the hemispheres of the brain have developed laterali/ed specializations that permit a complementary division of labor (Springer and Deutsch, 1993). For example, the left hemisphere in humans is far more involved in language processing than the right; both Broca’s area and Wernicke’s area, the verbal centers of the brain, are located in the left temporal area. In contrast, the right hemisphere excels at spatial perception. In addition, the left hemisphere is thought to dominate in analytical thinking and the development of coherence from multiple sensory inputs, whereas the right hemisphere appears more linked to emotional responses and detection of exceptions from multiple inputs (Ramachandran, 1995). Coordination of the activity of the two hemispheres appears to be controlled in part by an automatic “switching” mechanism, whose function can be measured in the laboratory by the alternating perception of conflicting visual inputs to the right and left eyes (Miller et al., 2000). Exogenous activation of one hemisphere, using caloric vestibular stimulation or single-pulse transcranial magnetic stimulation, can increase the time that the input to the contralateral eye is perceived. The same research group demonstrated that the “switching” mechanism functions on a distinctly different rhythm in people with bipolar disorder. They hypothesize that this delayed switching may be related to the profound mood swings that characterize this disorder (Pettigrew and Miller, 1998). This research suggests the possibility that guided eye movements, such as those used in EMI, may be able to stimulate the hemispheres of the brain, similar to the action of exogenous activators, and affect the attentional signals used in processing and thus the perception of memories and other information. Similarly, it is possible that, in the face of overwhelming experience, the “switching” mechanism is disturbed and permits the development of the sort of disequilibrium of perception that characterizes many post traumatic stress disorders.

Another area in which eye movements have been extensively studied is sleep. Although rapid eye movements (REM) that resemble saccades are well known to occur in sleep, they are not the only type of eye movement that can occur. Slow rolling eye movements, with some similarity to those used in EMI, are characteristic of Stage 1 sleep, which also involves production of theta waves arising from the hippocampus. It is also known that people recall dreaming (if the definition of dreaming includes any mental content, whether narrative or non-narrative in structure) when awoken from REM or non-REM sleep (reviewed in Nielsen, 2000). In addition to the restorative role of sleep, many researchers now believe that sleep plays a critical role in memory consolidation and learning. Since the process of integration facilitated by EMI involves accessing and transducing memories, and since the eye movements of sleep and EMI share certain similarities, an exploration of the mental activities during sleep may shed light on conceivable mechanisms of EMI. In particular, it is possible that highly distressing memories that routinely disrupt sleep when activated—either in the form of nightmares (in REM sleep) or night terrors (during slow wave sleep)—remain fragmentary and isolated from integration with less distressing content because they do not undergo the normal consolidation processes during sleep that are essential to learning (Gais, Plhihal, Wager, and Born, 2000). The use of a wide variety of eye movements in EMI may be providing a “second chance” for this required consolidation to occur.

A final area of research involves the observation of disturbances of eye movements in people with schizophrenia. Disorders of eye movements have been used as a biological marker to assist in the diagnosis of schizophrenia. Dubbed eye-tracking dysfunction (ETD), the observed abnormalities constitute disruptions in normal smooth pursuit eye movements (Holzman, 1985, 1992). Up to 85% of people with schizophrenia often show slowed velocity in eye-tracking tests, as well as saccades away from the target and velocity arrests. Schizophrenia is characterized by incoherence of perception and thought, hallucinations, and poor integration of sensory inputs. This association of disordered thought and sensory perceptions with ETD raises interesting questions for peo-
people with psychological trauma. Could patients with traumatic memories present similar difficulties in integration of sensory information and manifest disordered thought patterns as a result of their stressful experience? It is very tempting to speculate that there is an underlying connection between these processes and that the eye movements in EMI impose an external source to overcome the processing deficits temporarily induced by trauma.

These various lines of evidence, as well as the existence of other eye-movement-based psychotherapies, begin to provide hints at the underlying neurobiological basis for the efficacy EMI demonstrates in clinical settings. Clearly, further research will be needed to clarify which of these mechanisms is at work and which other elements of EMI contribute to its effects.

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 transformative 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.

In addition to its ability to help people in distress, EMI offers a new way of examining the nature of memory, consciousness and multisensory experience. It is my hope that research on the application of EMI will also lead to new insights into the functioning of the human mind.

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