

NLP Strategies
Integral Eye Movement Techniques
(IEMT[®])

Designed by Andrew T Austin

Manual for Practitioner Training



Training Professionals
with an eye for accuracy

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If you have any eye problems excluding short or long sightedness, or if you have recently suffered a trauma to the eye, i.e. a black eye, or any of the contraindications supplied before the start of this training, please let the trainer know, as you may be asked not to participate in some elements of the exercises during the training.



What is Integral Eye Movement Therapy (IEMT)?

Integral Eye Movement Therapy is a brief observational change work process that can generate rapid change in undesired emotions and identity imprints (formative experiences of belief and understanding/learning). The process and algorithms of the therapy answer the question “How did the client learn to feel the way that they do about the thing that troubles them” (how do they remember what to feel)?

By building resources inside the problem state, this brings the client more into the present and allows the client to stay out of past negative experiences permanently.

Part of the structure of the IEMT model is the provocation of specific behavioural responses from the client in order to create change. The behavioural responses that are stimulated, are the behaviours that make up the “Five Patterns of Chronicity”.

Change is brought about rapidly by recognising these patterns of chronicity, as they emerge and highlighting these as they are observed, allowing the client to notice the improvement in the reduction of intensity of the emergent of negative kinaesthetic memories and identity imprints as the session unfolds.

For the practitioners, IEMT is about precise calibration when working in-person and adaptations can be made to effectively use IEMT online. Unlike some other treatments using eye movements, the movements that are chosen are neither random nor a repetitive left to right movements in the hope that change might occur. The training provides the tools for the students to start to precisely calibrate which axis to move the eyes through, thus enabling change to occur with extreme precision and astonishing speed.

IEMT is not the grand unified theory of therapy and change-work, but rather it is a very useful technique for the practitioner to have at hand and provides an excellent remedial process for emotional change and a generative source for identity change. IEMT can enable excellent results where previously a good outcome might have appeared improbable.

Experience shows that the application of eye movement therapies is particularly effective with regards to intrusive imagery and “flashback” phenomena. Essentially the method involves holding the problematic imagery in mind while the eyes are directed to move, while calibrating to the clients’ responses that occur during this. The results of this are often that the imagery loses its emotional impact and becomes far less disturbing.

Integral eye movement techniques were originally developed out of NLP pioneers Steve and Connirae Andreas' model of eye movement integration (EMI). This followed the observation of a number of neurological phenomena that occur during the therapeutic eye movements, occurring at the moment that the problematic imagery changed its emotional coding. Later Andrew T Austin developed a specific set of applications of this phenomenon so that Integral Eye Movement Techniques can be applied to the areas of neurological imprints specifically, imprints of the emotion and some of the imprints of identity.

Identity Imprinting

Emotional imprinting occurs when a person lays down a new kinaesthetic response to an experience or stimulus. This teaches the person how to feel and respond about certain things. For example, how many of us when told by someone senior that they would “like a word in your ear” immediately feel like a school child about to be scolded. This is an emotional imprint in action in the current moment.

IEMT addresses and starts to resolve the question. “How did the person learn to feel this way about this thing?”

Identity imprinting occurs during lifelong development and is constantly evolving and changing. Many aspects of identity are attributed and occur neurologically as a feedback response to the environment. An example is a footballer who is seen as a star, an icon by his team and fans, who leaves to join a neighbouring club, can suddenly become a traitor, a figure now identified with ridicule, and scorned by the same people that they once delighted.

Other aspects of identity are more permanent and “feed-forwards” into the environment. These are 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 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 the person learn to be this way?”

In some cases, the person can adopt aspects of identity which can be problematic. For example, an emotional imprint might be, “I feel angry”, whilst an identity imprint might be, “I am an angry person” or even, “I am volatile.”

By specifically addressing the identity imprint this enables the practitioner to by-pass the belief that often supports undesired identity such as, “I cannot deal with this because of my volatile nature.” And so forth.

IEMT is a brief technique and a continuously evolving field that enables a core state change in minimal time. The two-day practitioner training covers in depth both emotional and identity imprint models, including the ideas around the relevant neurological, anatomy, physiology, the manifest neurological phenomena, and the skills required for delivering the model effectively and elegantly.

Neurology and IEMT

Understanding of the brain and the way it functions can be a tricky subject to address as the research is in a constant state of flux, the details given here reflect my best current understanding of how I believe the brain interacts as a full system and metaphorically, as there are still gaps in how things are fully processed. New research is changing and updating our knowledge of what is happening within the brain on nearly a daily basis, so it can be advantageous to follow the latest neurological research to add to your knowledge. Also remember that the Limbic System and brain is a part of a much larger system.

The Limbic System

It is questionable if the Limbic System is actually a system, but the components associated with it do seem to play a key role with the accessing and laying down of memories, emotions, behaviours and our drivers, all of these components are deep inside the brain sitting above the brainstem. Both hemispheres of the brain are symmetrical, but functionality can differ, each hemisphere are linked by the **Corpus Callosum**. Sometimes the Limbic System is referred to as the mammalian brain, midbrain, or emotional brain. This system has effects on our state and influences many things including **The Cerebral and Prefrontal Cortex** which is responsible for higher functions like language and problem solving, remember parts of the brain do not work in isolation from other parts.

The Amygdala (Alert/Panic button)

If we were to view the limbic system as a construction that contains other rooms and furnishings, within such a valuable building we would require a security alarm system, the amygdala could be seen as the alarm system, waiting for events outside what is desired, then taking the appropriate action. The Amygdala are our own personal panic buttons, which can cause a cascade of reactions to quickly take place, these allow us to respond appropriately to danger, making comparisons to past imprints to determine what might be the best action to take, but it can also be activated inappropriately causing fears and anxieties and is also associated with the process of depression and PTSD.

The Amygdala can give a higher significant response to strong emotional experiences like feelings of shame, joy, love, grief and the forming of fearful memories, the amygdala can go into overdrive and have the rest of the brain to pay more attention to what is occurring, this can cause memories to be created with much greater accessible details than would normally occur. The Amygdala also plays a role in the pleasure response with

a suggested link to binge drinking. Electrical stimulation of the Amygdala in animals has been found to increase levels of aggression/anger, the size of the Amygdala can vary depending on a number of factors, if you have a large social network the Amygdala will tend to be larger or if you are isolating with depression, they will tend to be smaller than average. The left and right Amygdala seem to differ in the way they respond to memories and the way they process emotions. Damage to the Amygdala can result in hyper-orality, hyper-sexuality and disinhibited behaviours which can be typically noticed with Kluver Bucy Syndrome, or similar effects might also be noticed temporally when a person is in a state of intoxication.

The Hippocampus (transition to long-term memory / GPS – Date Stamp)

In our building this would be the close circuit television cameras, encoding real-time events and the location of the cameras, feeding the images to monitors, noticing what is happening at that current moment, then stored onto the systems hard drive or other storage device, and these can be reviewed at a later time, if this link was to be cut or damaged by a burglar no new information would be recorded.

The Hippocampus works with the Neocortex of the brain (Memory Consolidation) it helps to lay down all our memories in a sequential order and identifying the location where we were and where we are currently situated, it is an essential component in the transference process of short-term to long-term memory, if the Hippocampus are damaged by accident, disease, medical error or substance abuse, it may stop or limit the creation of new memories or retrieval of past memories, this can be observed in people with Alzheimer's and Wernicke–Korsakoff Syndrome. With the **Cerebellum** storing core functions/skills/tasks

The Hypothalamus (Primal behaviours related to survival. eat, drink, and reproduce)

This would be the environmental control system in our building regulating the temperature, humidity, lighting cycles and checking the power back-up systems are ok or if they need an additional charge.

The Hypothalamus is pivotal in the operation of the autonomic nervous system (ANS) and endocrine system. The ANS works hand in hand with the Hypothalamus and operates things like breathing, blinking, pupil dilation, sleep, blood pressure, sex drive, hunger, thirst and so on, without us having to consider this consciously, keeping everything in balance and collating information from other parts of the body including the Vagus nerve, brainstem, and optic nerve amongst others. Some interesting hormones that are influenced by the Hypothalamus are Thyrotropin, Oxytocin, Dopamine as well as growth hormones.

The Thalamus (distribution system)

The Thalamus would be the hub (junction) where most of the sensors within the building would relay current information back and forth comparing to permitted thresholds then deciding what is appropriate to act on.

The Thalamus scans the rest of the cerebral cortex for activity and processes all our sensory data except smell, which is routed to the hypothalamus then via the **Cingulate Gyrus**, before then being routed into the Thalamus, the interaction of these signals plays a part in selecting what we want to pay attention to, the recognition of smells, prior perceptions, processing pain and significant emotions. In some cases, it appears over stimulation of the Thalamus can be expressed as obsessive behaviours.

Other areas that might be of interest that are involved with the movement of the eyes are -: **Anterior Cingulate, Basal Ganglia and Cerebellum (motor function memory), Ventromedial Prefrontal Cortex Ventral, Tegmental Area**

Note: -

Having a basic knowledge about neurology can be useful in answering client's questions. There are many other components to the ones that have been mentioned here, but don't lose any sleep over taking all the information provided in straight away.

You may work in a specific field and tailor your knowledge of the brain's functionality to support your field of experience e.g., Addictions.

The cranial nerves play a large role in the control over facial expressions including the movement of the eye muscles and regulation of the body after it encounters a stressor, and the cranial nerves will be involved during the processing of your work.

What we believe is happening.

Typically, when events happen, during our sleeping hours the learnings and events of that day are transferred from our short-term memory and archived into our long-term memory (via the hippocampus), with some extremely troublesome events this does not happen, when the memory is not processed into our long term memory, this memory can develop a strong connection with the amygdala, this can result in problems for an individual. When the eyes move there is a huge amount of electrical processing happening throughout the brain, this is why you are asked to keep your eyes still when having a brain scan, otherwise the results wouldn't be as clear. We intentionally want this process to occur during IEMT, IEMT helps recreate a state that occurs naturally, by holding the memory in your awareness and deliberately moving the eyes in a calibrated way, briefly re-stimulating the memory so that the emotional rating given by the

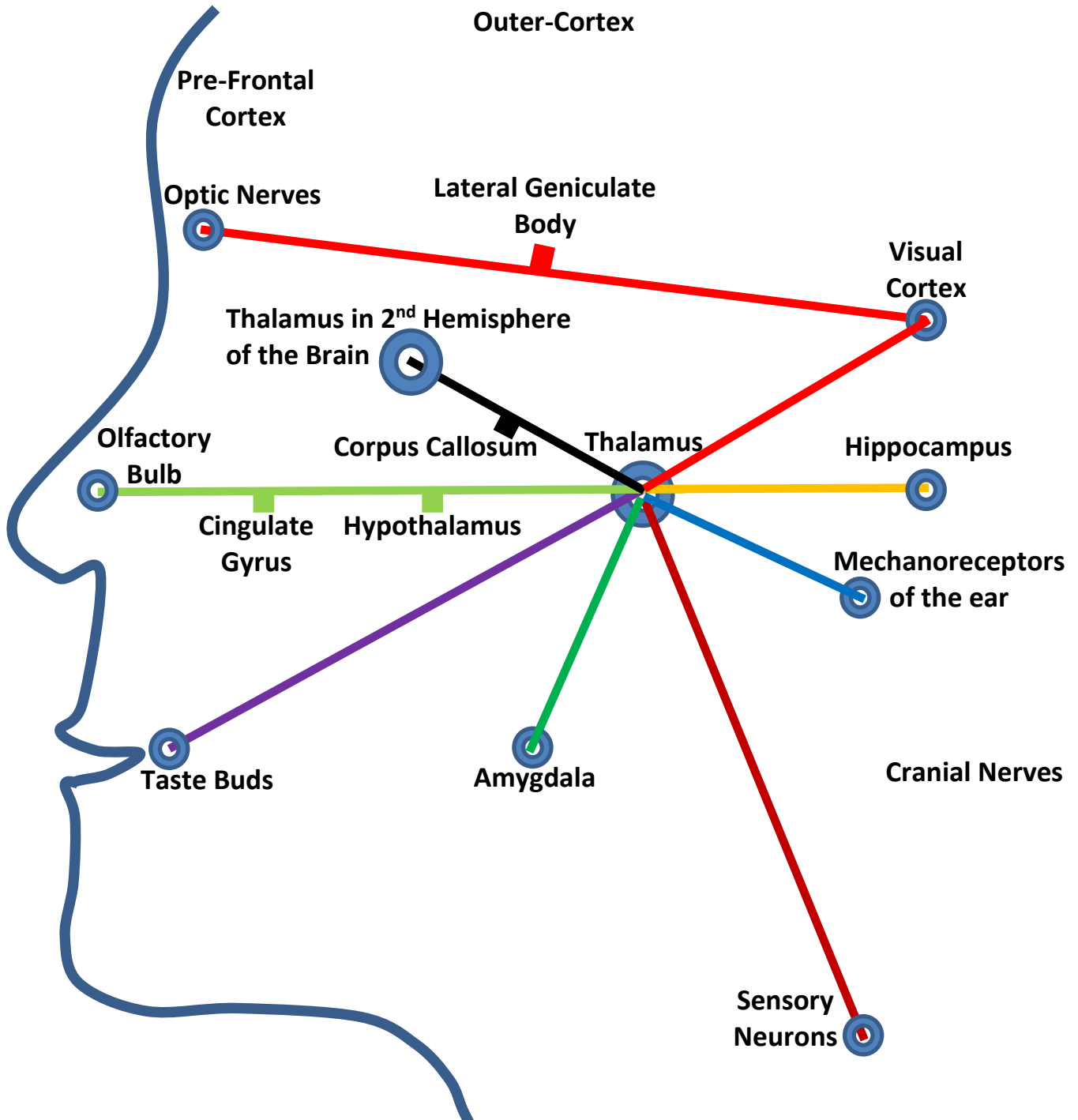
amygdala begins to be appropriately readjusted, allowing the completion of the event as a learning into long-term memory, muting the old response as the brain rewires (Neuroplasticity).

The Brief History of Eye Movements

Eye movements have been used therapeutically since at least the 1930's, and it is possible that they could have been used much earlier than this, but I haven't come across any evidence for this yet. John Grinder and Steve Andreas who were both influential in the field of Neuro Linguistic Programming (NLP), independently worked on using eye movements during the formative days of NLP, then from the work of Steve & Connirea Andreas, Danie Beaulieu (EMI) and Andrew T Austin (IEMT) developed their own differing models, while Francine Shapiro (EMDR) developed her own expanded model from John Grinders work, and later Brainspotting was developed by David Grand from observations made while using EMDR, but with all having a completely different approach.

Basic Tube Map of the Brain

The diagram below shows some of the components of the left hemisphere of the brain and the connection to the right hemisphere through the **Corpus Callosum**.



Please note that like the London underground map this is purely representational and not anatomically correct or to scale. Other areas of interest with additions are: - Dorsal Striatum, Orbital Frontal Cortex, Insula, Substantia Nigra and Nucleus Accumbent.

IEMT Training Structure

Practitioner Level – Creating Change

Part 1. Emotional Engineering – Depotentiating Imprints of Emotion with IEMT

- Introduction to the IEMT structure
- Eye movement and 3D accessing cues
- Introductory exercise and calibration of representational change
- The IEMT basic pattern and imprint tracking
- Post-Traumatic Stress Disorder (PTSD) and time coding
- The IEMT complex pattern (making it easier)

Part 2. Identity Re-imprinting – Updating our way of being with IEMT

- Introduction to the structure of identity using pronouns
- Four primary identity references – I, ME, SELF, YOU
- The IEMT identity pattern (simple form)
- The IEMT identity pattern (complex form)
- Physiological state accessing cues
- Changing unconscious state accessing
- Changing the negative Kino-Somatic Imprint

The IEMT Exercises

Kinaesthetic Transderivational Search

1. **Anticipatory or current state change**
Simple pattern
2. **Anticipatory or current state change**
Complex pattern
3. **Updating identity imprints with IEMT**
Simple form
4. **Updating identity imprints with IEMT**
Complex pattern

Physiological State-Accessing-Cues (PSAC)

1. Eliciting the model
2. Incapacitating the unconscious physiological access to the negative state and installing a positive state
3. Changing the negative Kino-Somatic Imprint

Anticipatory or current state change

Basic pattern

Elicit the undesired state (whole being) or kinaesthetic expression (part of body feeling)

- **Ask the client to assign an amplitude (intensity) scale (0-10)** “...and out of ten how strong is this feeling, with 10 being as strong as it can be?”
- **Ask** “...and how familiar is this feeling?”
- **Ask** “...and when was the first time *you can remember feeling this feeling... now...* it may not be the first time it ever happened, but it is the first time that *you can remember this now?*”

Allow the client time to access the imprinting event (this typically can be 20 to 40 seconds). Do not offer any guidance or advice and allow the client to perform this on their own kinaesthetic transderivational search (going inside to find the information).

When the client has accessed their earliest recollection:

- **Ask**, “...and how vivid is this memory now?”

Instruct the client to hold the memory vividly in their mind for as long as possible...

Guide the client to perform eye movements through different access points. Periodically prompting the client with “hold on to that memory”, “and keep trying to hold onto that memory” or “and if this memory fades, try really hard to bring it back” or “try as hard as you can to hold on to that memory, that happened”.

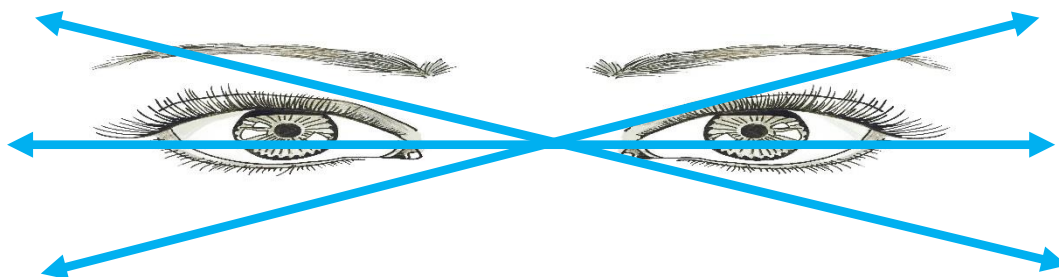
Guide them through the eye movement for about 20 seconds or less before rechecking with the client.

Test 1. Ask “...and how does that memory feel now...?”

Test 2. Ask “...and what happens when you try accessing that feeling now?” If the imprint event still triggers a negative kinaesthetic, repeat the process.

(Optional) Test 3. Ask “...and when you think about that <ANTICIPATORY EVENT> event now, what feeling comes up for you now?”

If a negative kinaesthetic emerges then repeat the basic process and locate next imprint.



Anticipatory or current state change

The Complex pattern (Calibrated)

Elicit the undesired state (whole being) or kinaesthetic expression (somatic feeling)

- **Ask the client to assign an amplitude scale (0-10)** “...and out of ten how strong is this feeling, with 10 being as strong as it can be?”
- **Ask** “...and how familiar is this feeling?”
- **Ask** “...and when was the first time *you can remember feeling this feeling...* now... it may not be the first time it ever happened, but it is the first time that *you can remember this now?*”
- **Again, allow the client time to access their earliest imprinting event (this typically can take between 20 to 30 seconds). Do not offer any guidance or advice, allowing the client to perform this without interruption as they start checking with their own kinaesthetic transderivational search.**

When the client has accessed their earliest recollection

- **Ask**, “...and how vivid is this memory now?”

Instruct the client to hold the memory vividly in their mind for as long as possible...

Guide the client to perform eye movements through the different access points for up to a maximum of 30 seconds and preferably shorter.

Suggest to the client that they can allow their memory to “...**move around through time to different events, experiences and memories, the logic of which need not make sense...**”

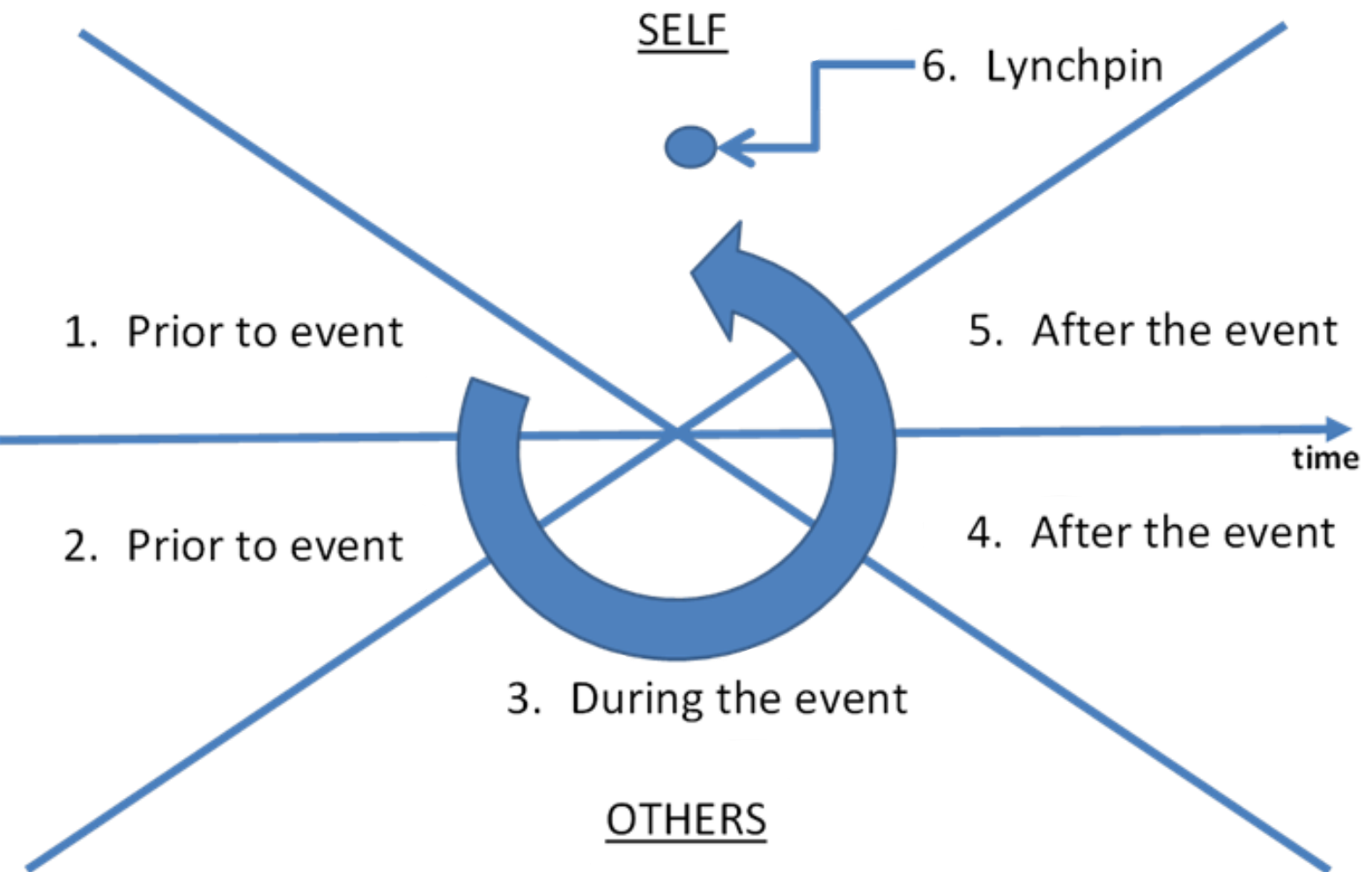
Whilst continuing to perform the eye movement sequences, you can instruct the client, “...**and if you wish, you can talk to me as this happens, tell me what images come to mind as we do this...**”

Observe closely for any state shifting and changes in their representation. These are often represented by muscular facial twitches around the eye etc. at each shift prompt the client’s awareness. “...and what was that one there...” etc.

To maintain a state that keeps the client in the present moment, it is important, when possible, to have the client talking to you through their experience, as you do this, move through different representations. Usually long forgotten emotional imprints can arise, but do not prompt for these or suggest what may occur. Use the eye movements for up to a maximum of 30 seconds before allowing enough time for them to process what has happened, then checking where they are with their representation changing.

This page is intentionally blank for you to add an additional handout about the eye movements, this is supplied during the training.

The Lynchpin



In the illustration on the previous page showing “The Lynchpin”, the focus is on an event that happened to another individual, the diagram is explained to a client by your telling of another person’s similar experience, this is to keep your client out of their own trauma that they went through as much as possible.

After the event occurred there may be other significant figures that are impacted and have changed their response to how they are around the client that has experienced the traumatic event, or this maybe expressed in the client’s behaviour towards other people, it can be useful to work later with these responses individually from the Lynchpin or if the client sees this as the problem these can be addressed initially.

Also, pre-describe what you are about to do with the client (“I will just explain how I work with this model with others, to check if it is suitable for you before we start”).

The Lynchpin summary

- Draw a similar diagram to the one on the previous page for the client to view.
- Explain each various section to the client, including the division between self & others.
- Tell a story or stories of a previous client that parallels the client’s experience, this is to minimise the client eliciting their own traumatic experience.
- Start recollecting to the client the story of a previous acquaintance who experienced a similar event, giving their perspective of events leading up to the traumatic event (point 1 of the diagram just prior to event/self), then work round the Lynchpin diagram in an anti-clockwise direction (2 – 6), giving your acquaintances perspective of what happened or what they guessed might have happened for each segment.
- When getting to the final segment, explain your acquaintances Lynchpin, this is so that they understand what the Lynchpin is before asking them the key question, **“do you have one of these”?**
- When the client says “yes”, say **“hold that”**, then take them through the eye movements for up to a maximum of 20 – 30 seconds or till there are no further axis deviations whichever occurs first. Allow the client enough time to process what is happening internally before resuming the process if required.
- There may be more than one Lynchpin, in which case ask them to choose the one that is most prominent for them, then work on this first.
- If the client shows signs that previously may have been classed as a somatic abreaction, when using the Lynchpin initially consider it as a response to their internal process, so allow the client enough time to process through whatever they are experiencing.

- After resolving the Lynchpin there may still be other issues that want resolving, for which you can use other elements of the IEMT model, or other approaches if appropriate.

Post Traumatic Stress (PTS) can occur as the result of a person's response to an event, such as, a sudden shock, an accident, acts of violence, disasters, death/suicide, robbery/burglary, rape/sexual assault, birthing or witnessing a traumatic incident, a life-threatening experience, were they experienced the feelings of Fear, Terror, Helplessness or seemed Trapped. Our focus is not on the event but the individual's internal response to the event.

Some of the symptoms and behaviours that may be reported are, feeling disassociation from their body or the present, hyper-virulent / hyperarousal or hyporarousal, being triggered into a past event, withdrawn from society / self-isolation (alone, only I understand), avoidance of friends and family, self-medication, revenge, anger, guilt, loss, fear, anxiety, disturbed sleep (nightmares/night terrors), avoidance or compulsive behaviours.

Most clients with PTS will be in one of two categories those that can tell their story though it is uncomfortable for them, or those who cannot tell their story without being drawn back into the event, and with the second group the Lynchpin will allow them to connect with a key moment, where other approaches would be unlikely to allow this type of accessing.

While gathering information during your intake if a client experiences any distress, it is highly important to do a break-state (reorientate them back to the present) before continuing, as there is no value in the client re-experiencing the horror of the event. Use the concise information gathered during your intake procedure to plan your stories to explain the Lynchpin.

Incrementing of episodic memory

We remember memories in an episodic format like scenes from a film or tv show. I'm not sure if this was always the case for our current formatting style of memory, but I expect that the way we view and digest media will influence our experience of how we recall and process memories.

Noting the start and end points of the memory, initially decrement the start point by a few seconds/minutes, prior to the starting point to an earlier point, also extending the end point of the memory by a few seconds/minutes, you can keep progressing the memory forward to the present day, this will help to destabilise the current memory, and change the unhelpful response to the troublesome memory of the event that has happened, as initially this will have a defined boundary when it is recalled.

In a similar way this can be applied to nightmares, we can change and imagine what the person would like to happen or play-out and extend the ending to a positive outcome, no matter how bizarre this might be, changing the path and presumed ending of the nightmare, as typically nightmares do not conclude and can be repetitive in format, have them rehearse this alternative, a number of times each day or before falling asleep, if they can't remember what the nightmare is, have them guess what it might have been and then have them do exactly the same process. In NLP there are ways of working that involve cognitively changing the event to elicit a different somatic response, and I have read of Dr Justin Havens, an EMDR practitioner using a similar approach to what was previously mentioned.

This can change how the brain consistently processes the event and introduces a Prediction Error.

There will also be an accompanying feeling or feelings that are associated with experiencing a Nightmare, you can ask the intensity of the feeling that accompanies the nightmare, then run the complex IEMT pattern on this. There may also be an associated feeling that differs from the nightmare that is present on awakening or a feeling like apprehension before going to sleep which both can be attended to using IEMT. E.g. ask "and when you are woken by this nightmare this feeling on a scale of 10 how strong is this feeling, and how familiar"

Additionally, when a nightmare wakes a person, introduce a strategy that they can implement as soon as they awaken that they will find comforting.

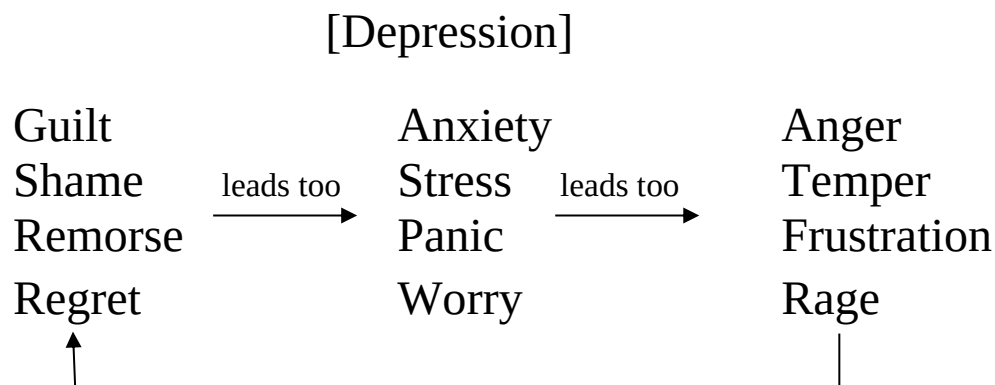
The symptoms of Post Traumatic Stress seem to resonate in our neurology, once that this is depotentiated, IEMT can be used to resolve the remaining emotional baggage around what has happened (hopelessness, sadness, regret, anger etc.).

If the client has a specific memory that is haunting them, you can simply say to the client, "okay",
"and how vivid is this memory"
"Hold that" – taking them through the Kinaesthetic pattern, after which ask
"and what happens when you think of that memory now"
"and what about the intensity of feeling that accompanies that"
"and out of ten how strong is this feeling, with 10 being as strong as it can be"? – which has led you back to the initial question of the Kinaesthetic pattern.

Note: - Only a psychiatrist or psychologist qualified in this field can diagnose Post Traumatic Stress in the UK, but forms like the PSS-I-5 can be useful in the monitoring of change before and after completion of IEMT, in a similar way that would be done with a SUD's rating.

The IEMT Three Pillars of Depression

Principal: Anxiety is not an emotion. It is an over-arousal of the autonomic nervous system (ANS) caused by underlying emotions. When these underlying emotions are resolved, the over-arousal of the autonomic nervous system reduces, and the anxiety is greatly alleviated. In many, but not all cases, these emotions will follow a common pattern. This pattern is as follows.



Feedback loop – Once the person is calm again after an outburst. The person again starts to feel guilty for how they responded/behaved and their failure in the situation, and this fuels the cycle to begin again.

An example: a person is prone to guilt and thus worries about offending other people or letting them down. So, they go about their day anxiously not wanting to let themselves or others down, but if other people tend not to behave in the right way, they find themselves exposed to additional anxiety provoking situations.

After a while, this tolerance wears thin and after suppressing the stress for a period of time, they eventually cross a threshold and release this with an angry outburst. In this situation, anxiety is a pillar that is propped up on one side by guilt, and on the other side by anger. By dealing with the guilt and its related emotions, and by dealing with anger and its related components, the anxiety often ceases, and the cycle will be broken.

Untreated this cycle can often lead to a sense of hopelessness, with the possibility of the body responding with the solution of the freeze response, which can become one factor that can lead to what seems like depression as the main symptom, they might not be expressive (internalised) of their anger within the model. The model might also have relevance to postnatal depression.

When introducing this model to a client I would not refer to it as a model of depression, if the client recognises the model as being familiar, after explaining the pattern to the client, let the client typically choose which emotion from the two supporting outer

columns they would like to work with first, and if you are limited for time, start with the rage and anger pillar as you do not want them clearing the other emotions, leaving them only with the emotions linked to anger at the end of the appointment.

Additional example. A person in a relationship is prone to delivering a torrent of verbal abuse to their partner, after which they feel guilt about the way that they behaved, and resolve to change, as they modify their behaviour they feel internally like they are walking on eggshells and the anxieties around this build, eventually a threshold is crossed and another outburst is triggered, after this subsides the person will circle back to feeling guilt again and the whole process repeats.

Updating Identity Imprints with IEMT

Simple form – Pronouns

Set-up: The set-up is key for the process to flow effortlessly. Allow sufficient time for the client to understand the concepts and give numerous examples of the interactions of the pronouns before you start enquiring into their representation.

Discuss the structure of identity with your client; explore themes and issues that are both culturally common and specific to the individual.

Introduce the concept of different aspects of identity such as, “I, ME, SELF, YOU.”

Introduce the concept of relationships between interactions of identity.

I despise my self – (‘I’ is despising of self)

I tell myself off – (‘I’ is talking and chastising self)

I like my self – (‘I’ is liking of self)

When I overeat, it makes me feel sick – (I’s behaviour is at cause of the feeling)

It’s not safe for you to trust anyone these days – (post hypnotic suggestion of beliefs and values)

Using numerous examples and feeding back their own language that they have used during the session, as a way of emphasising the identity shifts.

Andrew T. Austin uses the following example of the relationship between I, Me, Self and You.

“I had a cancer patient recently, who said something interesting to me. She said, ‘I didn’t realise just how much cancer would affect me. I guess inside my-self, I knew I’d always be ok, but what really shocks me is just how much cancer changes you.’”

Locate identity components in client

Ask: - “...and when you think of ‘I’, whereabouts is ‘I’?”

Ask: - “...and how old is ‘I’?”

Ask: - “...and what is happening around <insert age> year old ‘I’?”

The client will often ask for clarification on the third question – maintain your own state and offer no guidance. If the client gets stuck repeat the question

Repeat the same sequence for “me”, “self” and “you”.

Identify aspect(s) of identity that may be problematic, immature, or unintegrated.

Note: If “I” hates “self”, both parts may want addressing, i.e. “I” has an issue with “hating” and “self” with being hated and may have a behavioural issue that is hate-worthy, and so forth.

Instruct the client to hold images of, “what is happening around that ‘me’ (or other pronoun)” and have them move their eyes through the “lazy 8 (infinity symbol)” pattern, six times in each direction (clockwise, anti-clockwise), lasting no longer than 20 - 30 seconds then recalibrate.

When a client uses the word “you”, take it literally that they are talking about you and not themselves?

Further concept of unpacking possible relationship between levels of identity

I despise my self – (‘I’ is despising of **self** and **self** maybe acting despicably)

I tell myself off – (‘I’ is communicating in a chastising manner to **self** and **self** might be involved in unacceptable behaviour)

I like my self – (I’s liking of **self** and **self** could be indulging in a pleasing behaviour)

When I overeat, it makes me feel sick – (I’ is sensing a lack of choice and **me** has to deal with the consequences)

I had a client recently who said, “I have no confidence in **myself** whatever happens, and it always bothers **me** whatever I do, my confidence has just deserted **me**, I find that I cannot put any trust in **myself** to solve this, I suppose that it’s just one of those things that **you** are unable to change.”

Summary of possible interpretations

I – (i) untrusting, (ii) at fault (iii) lacking confidence (iv) making assumptions.

Me – (i) bothered (ii) abandoned.

Self – untrustworthy

You – cannot make change.

This method is a way of looking at our experience of identity, through how we can subdivide our interpretation linguistically, initially this work was developed by Andrew with additional ideas by David Groves.

Updating Identity Imprints with IEMT

Complex form

Set-up as in simple form

Locate the identity components in client

Ask: - "...and when you think of 'I', whereabouts is 'I'?"

Ask: - "...and how old is 'I'?"

Ask: - "...and what is happening around <insert age> year old 'I'?"

The client will often ask for clarification on the third question – maintain your own composure and offer no guidance. If the client gets stuck repeat the question

Repeat sequence for "me", "self" and "you".

Identify aspect(s) of identity that may be problematic, immature, or unintegrated. If "I" hates "self", both parts may want addressing, i.e. "I" has an issue with "hating" and "self" may have a behavioural issue that is hate-worthy, and so forth.

Instruct the client to hold the representation vividly in their mind for as long as possible.

Guide the client to perform eye movements through the different access points.

As you start to do this, instruct the client, **"...and you can talk to me as we do this"**.

Suggest to the client **"you can allow your memory to move around through time and different events and memories, the logic of which need not make any sense"**.

Whilst continuing to perform the eye movement sequence, instruct the client.

"...and talk to me as this happens, tell me what images and past experiences come to mind as we do this..."

Observe closely for state shifts and changes in representation. These are often represented by facial twitches around the eye etc. and at each shift prompt the client **"... and what was that one..."** etc.

Move the eyes through the lazy 8 pattern for a maximum of 20 - 30 seconds, calibrating to the eye axis deviations or until there are no further eye axis deviation, whichever happens first. Repeat until there are no further axis deviations, or their state change is complete, and representation is now current.

Updating Identity Imprints with IEMT

Complex form (part 2) changing of identity referential Index

Other personal Identity markers

Having addressed “I”, “me”, “self” and “you” examine other identity representations around the person’s name and titles.

For example, a man may be “Anthony” to which his parents and family refer, to his employer “Tony”, to work colleagues “Toe” and to his childhood friends’ “Ant” and so on, he may be “Sir”, “Dr”, “Mr” or “Master” in other contexts or possess some other title that provides a basis for a separate identity.

If incongruencies are identified, repeat the IEMT process on these areas.

Referential indices of third-party identity

Assuming your client already understands the concept of “representations” in three-dimensional space. If in doubt, explain with more examples.

Then

Ask: - “What representation do you have when you hear “Him?”.

Elicit visual representation and what the representation means to the client

Repeat for the appropriate following major themes:

Him, his, he

Her, hers, she

They, them, their

We, us, them

You can also explore pertinent themes such as: boyfriend, girlfriend, husband, wife, daughter, son, mother, mummy, mum, dad, father, daddy, and so forth.

Using IEMT Online

It is possible to use IEMT successfully online and it is the choice of the practitioner whether to use IEMT in-person or online, the main difference is that your attention is more divided observing information online initially, as it involves you being attuned to various aspects as well as focusing on the technique, there is also a slight time lag, which means with deviations, rather than saying **“and what happened there”** you could modify this to **“and notice what happened there”** on the second run, at the same point along the same axis.

Also make sure that you have clearly describe to the client what you are wanting them to do during the use of the eye movements, **“I will be guiding your eyes, and when my guiding finger moves beyond the screens limits, imagine you are still following this until your eyes reach a comfortable point to the outermost periphery of their movement”**. You can move your seat back from the camera to demonstrate what you will be doing when you are working closer to the screen, you can also choose to tailor the movements to the client, verbally marking just prior to when you are about to change to a different axis if this assists the client e.g. “Changing, to upper left quadrant”.

Have the client in full screen (Pin Video) and yourself as a thumbnail at the top of the screen, so that you can monitor how your guiding movements are viewed on the screen. The central point of the eye movement patterns, wants to be in the centre of the monitor screen, ideally the client’s eyes would be at camera height, but with most PCs or laptops, this would make it difficult for the client to follow your movements on the screen, so have the client sat in a position where they can easily follow you guiding their eyes, while keeping their head still (an option is that the client can hold their chin, or interlock their fingers cupping the back of the head to make them aware of any movement), and you are able to still monitor their eye movements as they do this, take a little time setting this up so they are comfortable and you have the clearest possible view of their eyes, head and shoulders, if it is possible you may also want to adjust the light to maximise the eyes visibility. If the client struggles thinking of the memory while looking at the screen, alternatively you can ask them to imagine that memory, being on your guiding point/fingertip as suggested by Sonia Richards in her book. A friend Julia Kurusheva takes a metaphorical approach, while guiding the eyes she uses an eraser on the end of a pencil as a focal point.

You may have to adjust the mirroring function on Zoom video settings, so that you are not viewing your movements reversed when working with a client.

Occasionally there can be a slight viewing discrepancy between what you are seeing, as the centre of the screen where your guiding finger is and what the client is viewing as

the centre of the screen, if this is the case have the client identify where the centre of the screen is for them and mark this level on your monitor using post-it notes.

State the hardware and software requirements for the client so that they can work effectively online, a phone would not be a suitable device to conduct a session on.

Check that the client has an appropriate space where they can attend the call, with both of you working in a location that is free from distractions and where confidentiality can be maintained. Have the client supply the name and contact phone numbers of two trusted people that are in close proximity to the client at the time of the session.

A technology check prior to the session can be advantageous if the client is unfamiliar with online video calls, this is to iron out any technical challenges that may arise beforehand. Make sure that all notifications are disabled on your own device before starting a session.

It can be useful to have a back-up if your internet connection destabilises, this could be achieved by connecting a mobile phones 4G/5G signal to your laptop or device.

Physiological State Accessing Cues (PSACs)

Exercise 1 – Eliciting the State Access Strategy

- Use rapport and state elicitation to enable the client to access recurrent negative/problem state.

Ask: “Do you have a negative that is a problem for you?”
Ask: “How do you know”
 - As the client answers, interrupt them with, “**show me**”, this will suggest that they access the state physiologically.
 - Observe and calibrate the physiological shifts the client uses for state access. Mentally make a note of these.
 - Make micro-adjustments of the client’s physiology. With each movement ask what happens when I do that, better or worse?
 - Then instruct the client, “Put it back to how it is supposed to be”, before making another micro-adjustment
 - If working online, ask your client to make these movements, “I would like you to tilt your head 1 centimetre to the left”.
- Do please note:** There is no need to drag this out. About a dozen micro-adjustments done in about 2-3 minutes is sufficient, remembering to be respectful of the client while making these movements.

Exercise 2 – Incapacitating the unconscious physiological access to the negative state

- Use rapport and state elicitation to enable the client to access recurrent negative problem state.
- Feedback to the client the physiological shifts that are necessary to access this state.
- Exaggerate their movements with your own movements and offer absurd verbal descriptions of the movements. Use humorous, rude, taboo and ridiculous concepts.
- **Remember:** avoid being offensive, reference only the movement/behaviour connected to the accessing of the state. Not body appearance, or anything that is not behaviour related to the accessing of the negative state.

Exercise 3 – Making the Negative State Uncomfortable Enough to Change

- Instruct client to access negative state.
- Encourage the client to exaggerate these muscular movements and tensions.
- Mirror the client as you do this, comically exaggerating the client's movements whilst encouraging them to increase the muscular tensions' posture etc.

Encourage the client to maintain holding the posture until it becomes too uncomfortable to maintain.

Patterns of Chronicity and Emotional Chaining

The 5 primary patterns of chronicity

Identifying and highlighting these patterns within your client's process is key in resolving the stuckness that the client is presenting, while allowing them to develop and implement alternative strategies.

1. Three Stage Abreaction Process

- Stage 1 signal (Implied Threat of Emotion)
- Stage 2 Increased amplitude of signal (Direct Threat of Emotion)
- Stage 3 Abreaction (Punishment)

2. The Great Big "What if..." Question

- Yes, but, what if [A], then [B], which means [C]

3. The Maybe Man Phenomena

The Maybe Man is uncertain of his or her own experience and this leaks through into their language. By remaining uncertain and vague there is no commitment to their experience or to their identity

Client – When asked about the intensity "well maybe the intensity might be a six or something like that, or maybe a bit lower".

Practitioner – "I like people to be specific, you say it might be a six or something like that, what is it really?"

Don't allow this vagueness of their own experience to go unnoticed, as you and the client will be working with an incomplete picture, when you notice the client uses vagueness interrupt their pattern, thus allowing them to start to access what they are actually experiencing. The exception would be in relation to time, as it might be unrealistic for the client to identify if they were 5 or 6 years of age when a specific event occurred. If any emotions arise when challenging them on this, use the eye movement protocol on these.

Maybe man sits on the fence avoiding commitment to certainty or change, allowing the person to develop a strategy from making the wrong or right call on decisions, this can be an element of a pattern linked with anxiety.

4. Testing for Existence of the problem Rather Than Testing for Change

Even though 99% improvement might be made, if the person with chronicity is able to locate 1% of the problem existing, this will generally be seen as representative of 100% of the problem existing. Make a record that you can feedback to the client about how they know that they have this problem on your intake form.

Client – “The intensity is a three, it is still the same”.

Practitioner – “It was a six and now it’s a three and there is no change, is that right?”

Client – “Yes, it’s the same”.

Practitioner – “if it was a six and now it is a three it must have changed in some way, true?”

Client – “eh” (continue prompting the client until they acknowledge that there has been a shift)

The client’s focus will be on the problem and not what has changed; it might take a short while but get the client to change their focus, so what has changed or is changing becomes their new focal point, seeding comparison points throughout the session that you will be able to reference.

You might have seen a video were a number of people are throwing (juggling) balls or skittles to each other, the object is to count how many times the objects are passed from person to person, but as this is happening a gorilla walks into shot, then out of shot, for a large number of people who watch this video they will be unaware that this has occurred, as their focus and attention was elsewhere, the same can occur with our clients, making them unaware of the changes that are taking place.

If the client can find 1% of the problem still remaining, that will be enough evidence of the whole problem still existing. Once people have had the gorilla pointed out to them it is unlikely that they will remain unaware of its presence.

If the client is unaware of the change that is happening. pause at this point until you draw their awareness towards the changes. Check for changes in the initial problem regularly, encourage the client to try and get the old feeling back to what it used to be until there is a verbal agreement that change has occurred, or check that they are 100% sure of movement in the issue.

Occasionally their focus may be on how bad things have been and are wanting to be heard, and for people to understand their suffering rather than making change initially

before they feel validated enough and ready to let go of any resistance towards change. Useful questions before the appointment can be – Will you know when this has changed and what will inform you of this (have them give the answer using sensory information).

5. Being “At Effect rather than Being At Cause”

By being “at effect” the person experiences emotional problems happening to them, rather than being something that happens as a process within them. A person “at effect” will seek treatment rather than seek change.

Client – “This government makes me really angry, and it is unbearable what they keep doing and then changing things, I despise the effect that this is having on me”.

Practitioner – (You could kindly and playfully provoke the client about being a puppet of the government to gain an additional response, or to have them change their stance about being passive to what is happening). “Do you enjoy the government manipulating and dictating how you feel emotionally, as you obviously let them control you (maintain rapport or reestablish rapport during this redescription of what was said, It can be useful before starting a session to mention that you may challenge their way of thinking to more quickly resolve things, and asking them “is that okay”?).”

Here the client’s only option seems for there to be a change in government to one of their liking, before things can change. Encourage the client to question their view until there is a shift in their perception, so rather than them being passive to what is happening they start to realise the part that they can play and become active in their own solution. If using humour like the example above (redescribing) to tease out some different thinking, an appropriate level of rapport is essential before doing this. The client may be tricky by insisting that they are in some way special but keep the focus on their behaviour.

You will also be picking up by now that in the above example that you could work with the clients anger “ME” that is angry, “I” that despises, also about the feeling of unbearable, and “They and ME” at a identity level

With the primary patterns of chronicity, rather than colluding with the client’s strategy, instead interrupt, disrupt, and point out these problematic areas, this will allow the client to change their focus and behaviours, allowing them to become more aware of their patterns themselves and start self-correcting. Remember to use the IEMT protocols to address any emotional imprints and identity imprints that arise while picking up on the client’s patterns of chronicity.

The Three Stage Abreaction Process

Stage 1 The Signal (Implied Threat)

- “I feel bad...” (There is usually a non-verbalised implication which suggests, “I am handing you the responsibility for changing the way I feel...”)

Example: “I have a headache with you doing this.”

Example: “I am angry with you pursuing this.”

Stage 2 Amplitude of the signal

- “**I’ve told you** that what you are doing is making me feel bad!” (“There is an increased emphasis on the signal, an increase in the symptom, and an increase in the implication that another person is responsible for the solution by changing what they are doing.”)

Example: “Now my headache is getting really bad.”

Example: “I told you that I was angry with you and still you persist.”

Stage 3 Abreaction – (Punishment)

- “Now I feel so bad, I am giving you no choice but to be responsible for my solution.” (This stage may take the form of a tantrum, or in extreme cases a convulsion, unconsciousness, total helplessness, becoming bed bound, being unable to leave the bathroom, extreme nausea, fainting, and so forth.)

Example: “Now I feel so bad we will have to stop; you will have to take me home.”

Example: “pushes the other person away and leaves the room.”

Thus, blocking the possibility of them making change, as their belief is it is you at cause, and not them.

Note:

1. This plays out in life when everyone in the social system is adequately trained in the meaning of the stage one symptoms, stage two and three become unnecessary. Escalation to stage two occurs when a new person enters the system and requires training, or an existing trainee dares to ignore or challenge the first signal, which is a breach of their rules.
2. At an intervention level, other participants learn to learn their mantra, “My behaviours are not controlled by the way that you feel.”

3. In changing one's own behaviour, the person needs to ask, "What am I really saying here when I report this symptom?" Or "what do I want to happen through acting out this behaviour?"

You can also choose to work on the emotions/feeling and identity patterns that arise during the early stages of a 3 Stage Abreaction or offer it back to the client to own using the words *That's Right*.

e.g. Client – You are making me feel agitated
Therapist - That's right you are feeling agitated

Client – This is getting really frustrating
Therapist - That's right you are getting frustrated

Client – You are making me so angry
Therapist - That's right you are angry

This can be the client's resistance to change which surfaces, playing out that, I will use my behaviour to make you (therapist/work colleague/ family member) change, this uses an escalating coercive format either verbally, somatically (headache), or taking a postural expressive nature, rather than the person being congruently assertive or expressing their own personal boundaries or genuine emotional distress.

Again, you can work with all the emerging emotions that the client reports.

e.g. Client – I am starting to get angry with the way this is continuing.

Therapist at stage two – That's right, I hear you telling me that you are angry, so this feeling of anger how strong is this feeling of anger, and how familiar etc. (if it is in the form of a somatic 3 stage abreaction (headache) you could do the same with this feeling)

OR

Using the Identity model, "and when you think of 'I' that is starting to get angry, where abouts is 'I'?" etc.

If you suspect, or you sense that the client could possibly become physically aggressive towards you, avoid using *That's Right* to get them to take ownership of their emotion, as your own safety comes first.

Additional general notes: - Occasionally when you are guiding someone's eyes they will pause, or stop during the process, allow this to happen momentarily and say "just notice what's happening there, and we are here now" then move the finger that you are guiding them with to get their attention, so that they can re-engage with the eye movements, on conclusion of the set of eye movements you can enquire what they were experiencing.

If a client refers to the problem as an image or a sound or another sensory system that doesn't relate to a feeling simply reply, "and when you think of that now what is the intensity of the feeling that accompanies this, and how familiar is this feeling, and when is the first time etc".

If the person says they are unable to recall the first time of feeling this feeling, respond by saying okay so when is the first time you can remember someone else feeling this feeling and again it may not be the first time, but it is the first time that you can remember now

After an appointment advise the client to do something enjoyable, relaxing, rest or sleep, as reconsolidation of memory will continue after the session.

The Great Big “What If...?” Question

As a trainer and presenter, I will often invite questions from people. One type of question that I will typically carefully avoid is the “What if...?” type of question. Engaging in a “What if...?” is risky business and can often lead to a stressful encounter with the questioners’ beliefs.

And here is something that is worth remembering – some people are so rigid in their beliefs they would often rather kill you or kill themselves than willingly change their beliefs. People have been assassinated, relationships have been destroyed, and crusades and world wars fought over whose beliefs were right.

People when happy or in a flow state will rarely engage in What If questions, using What If questions will also add multiple layers of complexity to finding an appropriate solution. The intention can be to anticipate and find solutions to future situations that may never occur, which can spiral into extreme scenarios. Running a “What If” pattern can lead to anxieties developing from this style of thinking.

Personally, I find it advisable to stay out of others’ beliefs.

So, here is how the “what if...?” question can function:

What if [condition A is true] then [condition B will be true]

Except that when someone asks a *what if* question, they rarely verbalise the *then* component out loud. This is a mind trap.

For example, in one training where I was teaching a number of different techniques for working with substance use. I was asked the following question.

“What if the client had been addicted for too long?”

What the questioner has done is find their own single counter example to the therapeutic generalisation that I was teaching. Anyone who has worked in teaching or training will be familiar with this scenario. The questioner already had the answer in their own head – their answer is then the component of the *what if* logic.

So, I asked the questioner, “Then what?”

To which they replied, “Then what you are teaching here isn’t a solution for addiction.”

To which I replied, “So then you already have your answer. So why did you ask me the question?”

To which they replied, “Because I thought it needed pointing out.”

To which I replied, “Then what is it that needed pointing out?”

To which they told me, “It needed pointing out what you are teaching isn’t a solution for addiction!”

Let’s break this down further. The questioner has asked. “What if the client had been addicted for too long [then what you are teaching isn’t a solution for addiction]”

But they had also missed out an important deletion, because what has been uncovered by my questioning of their questioning is;

“What if the client had been addicted for too long then what you are teaching isn’t a solution for addiction and will not work in the example I have in mind]”

What if logic is one of the ways in which negative beliefs can be structured. A third step in the logic is common to what if questions.

What if [A], then [B], which means [C]

Back to the training example

What if the client had been addicted for too long, then what you are teaching isn’t a solution for addiction and will not work in the example I have in mind],

which means I need to point out what you are teaching isn’t a solution for addiction.

During the workshop, this was the participant that tended to display an attitude that they knew more than the presenter. Attempting to answer their “what if...” question would have not necessarily helped the situation. To do so would have enabled them to further move into their beliefs and further counterexamples and would have led to a stressful exchange. I will check with some What If questions, if it relates to a situation that involves their relationships in the real world, and then answer these to the best of my knowledge.

So how does this apply to anxiety?

I am sure I am not the first person to notice that many anxious people ask themselves rather a lot of *what if* questions.

I just need to emphasise a point here: If you are asking yourself a question, it is because you do not have the answer. If you already had the answer, then you would not be asking the question, which means there is no value in asking yourself a *what if* question!

For example

“What if my mind goes blank, then my throat will go dry which means I have to avoid presentations”.

“What if somebody irritates me, then I will become angry, which means I must avoid other people.”

“What if there are no toilets there, then I might wet myself which means I cannot travel.”

With anxiety something else tends to happen. The anxious person asks themselves a rapid set of *what if* questions, and when trying to answer the *what if* questions, the following effect occurs:

What if [condition A is true] then [condition B will be true]
and
What if [condition B is true] then [condition C will be true]
and
What if [condition C is true] then [condition D will be true]
and
What if [condition D is true] then [condition A will be true]

When each ‘**then**’ component becomes the next level *what if* question before looping back to the beginning again. The number of levels varies, but with experience you will find people rarely move more than five levels before looping back to the beginning again.

Such as

What if I start crying then I will feel embarrassed
and
What if I feel embarrassed then I will look foolish
and
What if I look foolish then I will start shaking
and
What if I start shaking then I will start crying

There is a circular logic built into this type of thinking where A proves B which proves C which proves D which proves A.

Therefore, it is rarely beneficial to offer reassurance to a person asking a *what if* question or trying to answer their *what if* question – when they already have the next step which proves their belief to be already true.

A Solution?

Trying to reason the way out of *what if* logic is often a frustrating and a fruitless affair. The best solution is not to ask *what if* questions in the first place. This is possibly easier said than done. So, here are two alternatives.

Don't attempt to answer another person's *what if* questions. It really isn't worth anyone's time in doing so. The tried and tested formulae to use is to ask, "Well, then what?" and then to follow up with, "well then you have your answer" as in the first example shown on the previous page.

You can also use the eye movement patterns on the resultant emotion of a *what if* question, or the identity model or both can be used as a valid approach.

When you have found yourself asking yourself a *what if* question, the only realistic answer is, "Then deal with it", changing the persons focus to a solution. Alternatively, we can deal with emerging emotions that arise or an identity issue.

This is the main difference in attitude between a victim mentality (unknowingly passive) and someone taking back control (choosing to be active towards the problems solution).

For Example

"What if I miss the bus?" – "*Then deal with it*"
"What if I start sweating?" – "*Then deal with it*"
"What if it all goes wrong?" – "*Then deal with it*"
"What if I sing out of tune?" – "*Then deal with it*"
"What if they judge me?" – "*Then deal with it*"

What if questions in some cases, can be a part of Maybe Man phenomenon, where the person does not trust their own abilities to deal with a situation, so imagines a scenario where they would be at a loss at what they could do, if this is the case pass the question back to the person "good question what would you do in that situation", this allows them the opportunity to problem solve and find their own solution.

Therapy versus Training and Lifestyle

Where the client is unable to "deal with it" because they do not know how to do so, or they do not possess the appropriate resources and skills to do so, then this is likely to reflect on a training need rather than a therapy need, and appropriate training may be sort within the wider community. Alternatively, if you have an individual seeking help with a sleep issue, they may need to introduce Lifestyle changes, for example if they drink numerous cups of tea (caffeine) throughout the day, this can affect their quality of sleep, though there maybe causal issues that IEMT can address about their behaviour.

Case study guidance and becoming an IEMT Practitioner

- To become a practitioner the first step is completing in full both days of the IEMT workshop.
- In some cases, participants may have to complete requests from their sponsoring body before submitting their work to become an accredited IEMT practitioner.
- It is advised that you obtain a current enhanced Disclosure and Barring Service (DBS) form check.
- Registration with the IEMT Association, for which there will be a membership fee (currently £59) and an expectation that you will engage in Continuing Personal Development (CPD) while being a member and practitioner. Membership of the IEMT association will also allow you access to resources that will help to underpin your current learnings.
- For convenience it may be tempting to use friends or family for a case study, but I advise against this owing to potential difficulties regarding objectivity. It is also worth noting that engaging in any form of therapeutic relationship with close friends or family can negatively alter the relationship between those parties.
- Each case study wants to be of a session lasting approximately 45 to 80 minutes and involve using the key learnings from the IEMT training that are appropriate for the client, the case studies want to be much more than a demonstrating of the basic kinaesthetic pattern, and the case studies want to be with two or more different clients, highlighting any patterns of chronicity.
- All the information taken from your client can be used in your case study, making sure that it is not possible to identify your client from any of the information that you are providing, also that the client knows that you are in training, and you are using them as a case study towards becoming an IEMT practitioner.
- Confidentiality is paramount, so avoid using the name of your willing non-paying volunteer or anyone that they mention, you can use their initials or call them client 'A', do not supply their address, date of birth or any other information that might identify them or any other person they mention, but it is ok to record these for your own personal secure records kept in compliance with GDPR.
- Get as much practice as you can before doing the required 4 case studies. One of these case studies wants to be a recorded session and you could simply use Zoom or a mobile phone to record this, with supporting critique of the session. Make sure that the person you have asked to do the case study has agreed for you to share the video with your trainer, if doing this on Zoom I suggest having yourself

pinned in the video on a secondary device if this is possible, or if recording in person ensuring that you position the camera so that it is behind the volunteer or to their side, so that the cameras main focus is on you.

- Your case studies will be assessed on your interactions with the client, your awareness of any of the 5-patterns of chronicity that arise and any safeguarding issues during the session and using the IEMT model as described during the training and in the manual, you will be asked to submit additional case studies if you have not initially demonstrated this with your original submissions. Feedback will be given to assist you with any additional case studies that are requested.
- Each case study wants to be preferably over 2 - 3 pages and no more than 4 pages using a Calibri 12.5 font and submitted as a Word document or similar.
- You will be required to obtain insurance before you start to practise as a practitioner, suggestions for companies that can supply insurance are mentioned later in the manual.
- This **is not** a part of the certification requirements, I would recommend that you attend a first aid training and a first aid for mental health course, also participating in some safeguarding training could prove to be valuable.
- Make use of any follow-up Zoom calls offered after the training.
- All the above will want to be completed within 4-months of completing your IEMT training with Strategics NLP, it can be advantageous starting this immediately while everything is still fresh in your mind and if there is a genuine reason you are unable to complete the case studies within this timeframe, an extension can be arranged.
- Forward your written case studies and critique to iemtcumbria@gmail.com Password protect these documents and text me the password to 07773 712 191. Supply your videoed session, sending me a secure link to the video from Google drive or a similar sharing platform.

Things that you may want to include are: -

- Gender of client
- Age range of client 20-25, 25-30 etc.
- How you checked for contraindications
- The issue that they are requesting help with
- Number of sessions to date and the session number/s submitted for case study.
- If the case study is not of the first session and focusing on a specific session, give a brief summary of the progress up to date.
- Clients background information (health issues, dependencies, social problems etc.)
- Spotting patterns of chronicity
- Any other information that you believe is relevant.

Testing

- Give information on how you tested for change during and after the session.

Reflection critique

- Anything you may have done differently.
- What you did well.
- What the client reported experiencing during the session.
- Briefly reflect on where your attention was drawn during the session.
- What areas you might focus on in your next session.

Follow-up

- Make arrangements to contact your client about a week after their session, to discover what changes they have noticed while in their normal environment. Give a brief description of what has changed and not changed.

Use the information above to assist you in presenting your case studies. Please anonymize all information relating to the client and others that they may have mentioned. You will receive written feedback about your case studies, I may also contact you to ask you questions about the way you may use IEMT, as it is unlikely as a student that you will be working with a client who has PTSD, so I may ask for you to talk me through what you would do, or I may ask you about other elements of IEMT that are not mentioned within your case studies.

(Basic Details Intake Form & Assessment Guide Sheet)
please provide as much information as you would like

Issue (what is the problem)

What would you like to achieve (Goal)?

What does it stop you doing and is it ok to change this (Ecology)?

What would you like to do when things are resolved?

How will you know when things have changed?

First name

Surname

Address

Contact details phone: -

Email

Date of Birth

Who else lives with you?

Children

Occupation

What therapies/solution/help have you sort in the past?

What are your hobbies/interests?

How well do you sleep?

What are your expectations of the session?

What medication are you prescribed?

Any current or past physical health problems?

Contact details of 2 trusted individuals who will be in close proximity to you

Any current or past mental health problems?

Have you had or are you waiting for any operation?

Doctor's details

Assessment Consent Form for Integral Eye Movement Techniques

Practitioner name -

Date

Clients Name

Date of birth

Address

IEMT is generally a gentle technique, however occasionally clients may be asked to gain the approval off their GP's medical opinion or the opinion of an ophthalmologist that it is okay for you to attend IEMT appointments, this is if any of the following, or if anything similar to the following applies to you, except for statement number 9.

Contraindications

Please circle applicable answer

yes/no

- | | |
|--|--------|
| 1. Do you have any eye problems besides focal length? | yes/no |
| 2. Any Eye Disease (glaucoma, conjunctivitis etc.) | yes/no |
| 3. Recent Eye Trauma (black eye/detached retina etc.) | yes/no |
| 4. Neurological disorders (Epilepsy, Stroke, Head/brain injury, Parkinson's disease, Multiple Sclerosis, (Including psychogenic and factitious seizures etc.)) | yes/no |
| 5. Moderate or severe depression | yes/no |
| 6. Diagnosed with a personality disorder, psychosis, or psychotic illness | yes/no |
| 7. Any balance disorders (Meniere's disease, vertigo etc.,) | yes/no |
| 8. Anything that maybe similar to any of the above? | yes/no |
| 9. Might you have to give any legal evidence in the future? | yes/no |

I confirm that the information I have provided is correct.

Print name

Signature..... date.....

Dear GP, I require your consent that the above-named person is safe to proceed with IEMT appointments, which involves guided eye movements in a similar way to EMDR eye movements, if you require any further information, please contact me.

.....
GP's signature, practice stamp and date

Insurance

If you want to become a practitioner, you will be required to have your own insurance. There will be a few different companies out there, so, compare what is on the market. To get the ball rolling I have listed a number of companies that specialise in therapy and training below. They might also provide cover for you whilst you are in the process of training, and at a reduced rate.

Balens Insurance Ltd

Bridge House
Portland Road
Malvern, WR14 2TA
Phone 01684 893 006

www.balens.co.uk
info@balens.co.uk

Towergate Professional Risks

Kings Court
London Road
Stevenage
Herts
SG1 2GA
0844 346 3307

www.towergateprofessionalrisks.co.uk

Westminster Indemnity Ltd

No 5, 105 The Esplanade
Weymouth
DT4 7EA
0800 5353 666

<http://westminster-indemnity.net/wi/index.php>

IPTI

PO Box 106
Retford
DN22 1WN

Nicky on 01777 700383 or Martyn on 01777 703177.
e-mail us at nicky@ipti.co.uk or Martyn@iptiuk.com

<https://www.iptiuk.com>

BGi.uk

<https://bgi.uk.com/health-and-wellbeing>

Hiscox

<https://www.hiscox.co.uk>

Comply with your own country's laws and IEMT guidelines

This is just a brief overview of the subject of legal requirements, as there can be additional changes made to these frequently. If you are ever unsure about the law or legal requirements, check these out with a legal professional or your insurance company, or any organisation you may be a member of that may be able to provide advice. Different countries will differ in some way from the UK, so if you intend to work outside your native country check if there are any different regulations you must comply with.

Compliance

There are a number of different fields you will have to comply with when setting up in business in the UK like Health and Safety, Employment law, Taxation, Planning permission, Keeping clients information secure (GDPR), as well as abiding by any local council regulations.

If you have been provided with any specialist training which is current for example safeguarding training (protecting people or groups that may experience abuse, neglect, or similar problems), you would be expected to comply with the procedures you have learnt during the training, as you would be assessed as competent in this field. So, be aware of the knowledge you have already gained, and your limitations. Ignorance of the law is not a reasonable legal argument for not abiding by it.

Making claims about IEMT

Without medical evidence you are not allowed to imply or say (verbally, online, or in print) directly that your intervention will definitely help any health-related condition. It is also advised that you avoid terms like definitely, totally, 100%, cure, guarantee, as you may encounter problems with the Advertising Standards Agency (ASA), this covers things like websites and advertising. Avoid making unrealistic claims, as the results that we achieve are unknown.

Confidentiality

Confidentiality is paramount when working with a client, but there may be occasions when you may decide that it is prudent to disclose information, for instance when there may be a risk to you, the client, or someone else, or the requirement of a specific piece of legislation. Having a confidentiality policy within your website or within your literature can be an important step. Something like, I reserve the right to break confidentiality only if I judge there is a risk to you or to another person. This is very basic but covers all bases if the need arises. Again it is unlikely to happen but if you become aware of an act of terrorism you have a duty to report this, but this would be covered by the above confidentiality statement, as it would involve a risk to self or others, so in this case you would **not inform** the client you were planning to break confidentiality, but

contact the police as soon as the session finishes, as if you were to inform the client there may be a risk to your own safety.

What would you do if a client came to see you about a broken leg? It may seem like an obvious answer to this question, as you would naturally get them to attend a hospital if they had not already done so. But what if the client says that they are suicidal? Well, the minimum you must do is recommend that they see a doctor or another appropriate service about the issue, this is if you have had no appropriate training in this area. You may like to consider some other possible options, like contacting the clients' doctors' surgery, while letting the client know you are intending to do this as you are concerned about them. When contacting the clients GP surgery to inform them about your concerns, they usually reference patients by 3 criteria, name, date of birth and address, so you may want to gather this information along with their GP's details when taking the pre-session client details when they contact you.

If you intend to break confidentiality due to your concerns only supply relevant information relating to your concerns, things that have no relevance to your concerns in your client's notes should be kept confidential, as there would be no benefit to your client in supplying these. Data Protection is designed to keep information about your client safe but also allow the sharing of any relevant information safely.

Infrequently other issues may arise besides suicide such as domestic violence or other issues which may not be your main area of knowledge. So, it can be useful to find out which local groups and charities operate in your area and have a ready supply of their cards or leaflets to pass on to your client if you think it might be an appropriate service for them. You may have an interest in offering your skills to one of these organisations, doing some voluntary work for them, maybe to gain experience of a client base you would not normally come across within your practice. In some cases, you may also benefit from obtaining free training that may prove highly advantageous, and this could be valuable in your development as a successful practitioner.

So, if gaining more knowledge really interests you, ask around the various organisations in your area about what free training is available for things like suicide awareness, domestic violence, or maybe other types of relevant training you would like to master.

Health and Safety

As a private practitioner you will be responsible for your own and your clients' safety. You could check with your local council what is expected by them – It may involve doing a risk assessment before seeing clients, hygiene, including things like looking for possible trip hazards, and checking if the building's first aid box is fully stocked. There may be even some free local courses in your area so ask around local business groups or look online. You would be well advised to consider attending First Aid training which will be beneficial for your business and can be helpful also in everyday life.

Notifiable diseases – In the unlikely event that you encounter somebody with a notifiable disease. A therapist can decide that they wish to report a notifiable disease in individual cases, or you may choose to get advice from someone who is professionally knowledgeable about dealing with the subject. (<https://www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report>)

Notifiable diseases under the Public Health (Control of Diseases) Act 1984 are as follows: Acute encephalitis, Acute infectious hepatitis, Acute meningitis, Acute poliomyelitis, Anthrax, Botulism, Brucellosis, Cholera, COVID-19, Diphtheria, Enteric fever (typhoid or paratyphoid fever), Food poisoning, Haemolytic uraemic syndrome (HUS), Infectious bloody diarrhoea, Invasive group A streptococcal disease, Legionnaires' disease, Leprosy, Malaria, Measles, Meningococcal septicaemia, Mumps, Plague, Rabies, Rubella, Severe Acute Respiratory Syndrome (SARS), Scarlet fever, Smallpox, Tetanus, Tuberculosis, Typhus, Viral haemorrhagic fever (VHF), Whooping cough, Yellow fever

Also don't work with clients in person if you are suffering from something which is contagious, like impetigo or something similar, as there is a chance you may pass this on to your client.

Pre-Session Assessment Guidelines

The Association for IEMT Practitioners - Pre-Session Assessment Guidelines

Objective for Pre-session Assessment

The objective for carrying out a pre-session assessment is to eliminate candidates who may be unsuitable for treatment or intervention via IEMT. It should be noted that suitability for treatment does not imply or suggest the actual efficacy of IEMT for any given client. Simply put, not finding any contra-indications does not necessarily mean that IEMT will be effective for the client.

IEMT practitioners may have suitable training and skills other than IEMT, so the exclusion of a client from the IEMT treatment protocols does not necessarily imply that the practitioner should not work with the client using other processes and therapeutic mediums.

Common Factors Affecting Suitability

Ocular Disease:

Until there is sufficient medical evidence to suggest otherwise, eye movement work should not be used with any individual who has any active or current ocular disease process. There are no exceptions to this. Such conditions include conjunctivitis, glaucoma, history of detached retina and recent trauma such as "a black eye." Problems such as a "lazy eye" and poor focal vision are not necessarily a contra-indication unless there is an active and concurrent disease process underlying it.

Neurological:

All neurological disorders are to be considered a contraindication unless (i) you are medically qualified and experienced in the disorder and/or (ii) you have authorisation from the client's doctor to do so. Typical disorders include Meniere's disease (and related disorders of balance), multiple sclerosis, epilepsy (including psychogenic and factitious seizures), "stroke", history of head injury and Parkinson's disease.

Psychiatric:

A client may be unsuitable on grounds of mental health. Specifically, unless the practitioner is experienced and qualified to work with psychotic illnesses, or is operating with suitable direct supervision, then the history of psychotic illness must be considered a specific criteria for exclusion for IEMT work. When working with moderate to severe depression it is a requirement that the client's GP be consulted prior to IEMT treatment.

Legal:

If the client is a victim or witness of crime and is likely to be giving evidence in any legal process, then without exception, suitable and relevant legal advice must be sought prior to any IEMT treatment. IEMT is a process that directly affects memory recall and memory coding, and thus IEMT treatment may potentially be raised to question the validity of an IEMT recipient's testimony.

Avoidance and Appointment Substitution:

Occasionally a client may seek out IEMT treatment in substitution for their regular medical or psychiatric intervention, treatment and/or support. In all instances, the practitioners should request to liaise with the client's existing treatment services prior to treatment.

Method of Assessment:

All practitioners are expected to show good sense and judgement in pre-session assessment and are free to develop their own processes for assessment. Most commonly practitioners will use a written assessment form, often sent to the client prior to booking a session, or pre-assessment interview. It is up to each practitioner to decide whether this pre-assessment interview is without charge or not.

If retained, all assessment records must be stored according to international legal data protection criteria.

Referring On:

There is no requirement for any practitioner to accept a client or to "refer on" any client that they decline to see. However, it shows good practice to have a suitable network of health care professionals to whom to refer some clients, who may need support and advice for suitable treatment.

Additional Resources and Suggested Reading

Eye Movement Integration Therapy by Danie Beaulieu

- **Publisher:** Crown House Publishing (20 Aug. 2003)
- **Language:** English
- **ISBN-10:** 1904424155
- **ISBN-13:** 978-1904424154

Mapping The Mind by Rita Carter

- **Publisher:** University of California Press; 2nd revised and updated ed edition (18 Aug. 2010)
- **Language:** English
- **ISBN-10:** 0520266285
- **ISBN-13:** 978-0520266285

Integral Eye Movement Techniques The Definitive Guide by Sonia Richards

- **Publisher:** Nielsen
- **Language:** English
- **ISBN-10:** 1838496408
- **ISBN-13:** 978-1838496401

Steve Andreas – Eye Movement Integration digital download

<https://www.andreasnlp.com/store/nlp-training-videos/eye-movement-integration-therapy/>

50-minute DVD download with free detailed 6-page explanatory booklet. Recorded at the 1993 Fifth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy in Orlando, Florida.

Keep in contact and up to date with documents

Official Facebook group <https://www.facebook.com/groups/6561591767232693/>

<https://www.facebook.com/groups/25552908900/>

<https://twitter.com/freshbrainco>

Useful videos for your own personal use only:

The Lynchpin: https://www.youtube.com/watch?v=B7_A569OcDk

IEMT Q&A: <https://www.youtube.com/watch?v=FGuMvtyVmqU>

5 Patterns of chronicity: <https://www.youtube.com/watch?v=E12zAFnlYbk>

If you join the IEMT association, other videos are offered for you to learn from and enjoy.

Feedback sheets

After reviewing the information provided in your manual. Please feel free to make as many comments as you would like and use additional sheets of paper if required; there is no need to provide your name on this sheet.

How useful is your manual?

What could be improved in the manual?

What did you gain from your training / presentation?

What could have improved the training?

What would you like more of in the training?

What would you like less of in the training?

How did the training compare to your expectations?

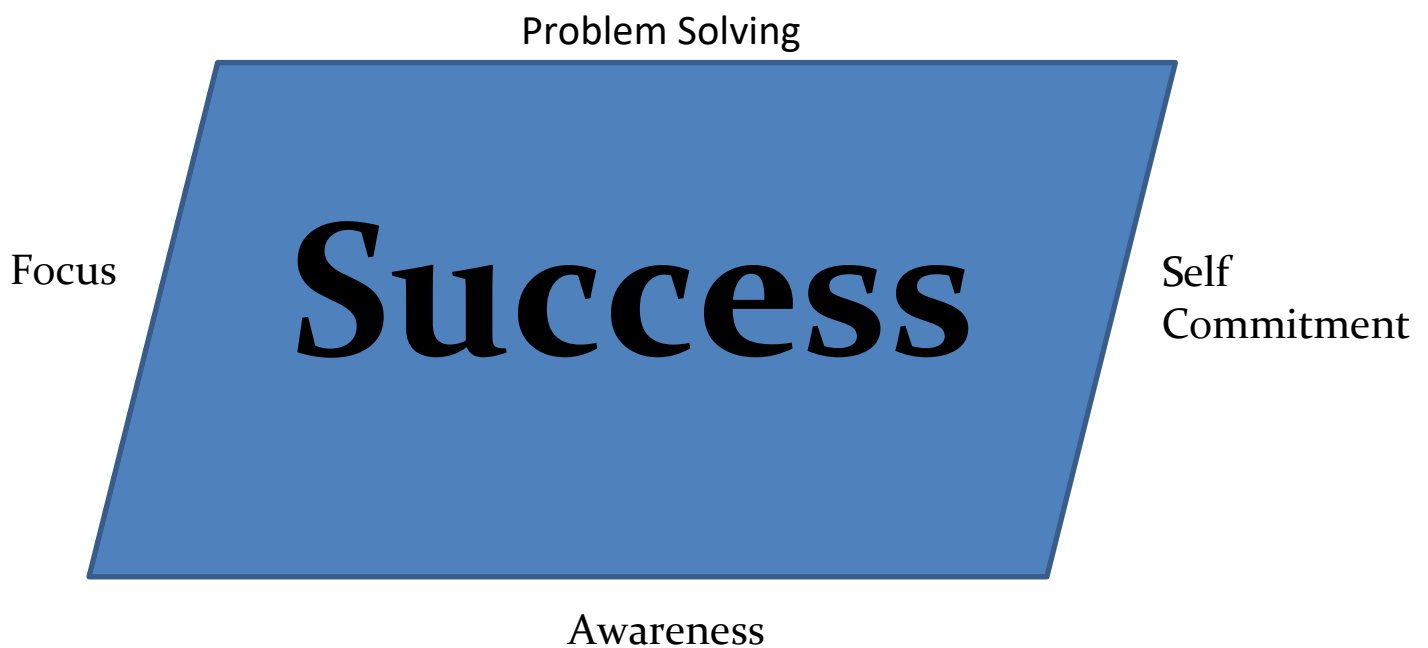
Please feel free to write any comments about your experience that we can use for publicising the course.

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Text message only - 07773712191



Notes