The Use of Integral Eye Movement Therapy (IEMT) in the Treatment of Psoriasis Induced Skin Eruption – a Case Study

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Abstract

Introduction: *Psoriasis is a non-contagious but chronic skin disease that does not usually affect the client's wellbeing, but, due to the changes regarding the aspect of their skin, other members of society tend to avoid and sometimes marginalize a person that exhibits clear visual symptoms. This can cause the patient issues like anxiety, stress and depression. In this paper, we outline and detail a case study with the treatment of a patient diagnosed with psoriasis and the effects of the IEMT model treatment. In addition, the IEMT primary concepts and techniques are described and further references and training resources are provided.*

Objectives: *The current paper aims at providing evidence for the IEMT model, both as possible and efficient, but also a non-intrusive, complementary method for treating patients diagnosed with psoriasis skin eruption.*

Methods: *The Integral Eye Movement Therapy process was specifically designed by the Association for IEMT Practitioners for their psoriasis research project.*

Results: *The client participating in this case study presented improvement after two weeks of the single IEMT based treatment session and after three months the client's psoriasis-induced eruptions completely disappeared. Moreover, after two years and a half, his psoriasis-induced eruptions also did not reappear.*

Conclusions: *Although further research is needed, following this case study, we can clearly see the Integral Eye Movement Therapy (IEMT) model shows to be a promising approach in treating stress-related psoriasis.*

Keywords: identity, Patterns of Chronicity, dermatological lesion, Eye Movement Deviation, neuroscience

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I. Introduction

Psoriasis, causes, effects and current treatment

Psoriasis is a type of chronic auto-immune, inflammatory, dermatological disease that currently affects around 2% of the worldwide population (Warren & Al-Nuaimi, 2017). The most visible result of this disease is the apparition of hardened tegument plaques on a person's skin, especially on their knees, elbows, hands and feet, and sometimes on the nails and the lower-back region. Psoriasis can manifest in lighter ways, when just smaller portions of the skin are covered by eruptions, or in medium to severe ways, when the skin areas become sore and covered with red hardened tegument plaques. A usual side-effect or evolution of psoriasis is the psoriatic arthritis, which can cause pain and the swelling of the joints, thus limiting the patient's capacity of using their hands (Ruderman & Gordon, 2016).

The risk factors regarding the causes of the psoriasis onset are not yet clearly identified, but studies revealed that they are mostly related to stressful life events, body mass index growth, smoking, alcohol use, skin infection and the use of beta-blockers and other anti-hypertensive drugs (Naldi, Cazzaniga & Rao, 2014).

Treatment for psoriasis usually includes medication allocated by a dermatologist, and most therapeutic interventions are based on Coal tar, Dithranol, Vitamin A (tazarotene), Calcineurin inhibitors, Phototherapy, Methotrexate, Cyclosporine A, Acitretin and Apremilast (Augustin & Radtke, 2016).

Although this disease is by no means contagious, a usual side-effect of the patients suffering from psoriasis is the marginalization suffered by the other members of society, because the appearance of the skin on their hands or other body parts seems to be different. This type of behavior expressed by other people towards the diagnosed patient can cause mental health related problems, such as social phobia, anxiety and depression (Donigan & Kimball, 2017).

Although psoriasis is treated through means of prescript medication, psychotherapeutic approaches have also become more frequent as a secondary or complementary approach, especially in reducing the emotional stressful disorders associated with psoriasis (Lowe, 1998; Savin, 1999; Shenefelt, 2006). For the purpose of this article, we can give the example of an eye-movement-based therapeutic approach described in a study made by Gupta & Gupta (2002) who used an EMDR-based treatment on stress induced psoriasis. In the study, four patients attended from three to six sessions in a period of four to twelve weeks, which showed improvement. As a follow-up, after six to twelve months after the treatment, they have maintained the improvement regarding their symptoms, made throughout the intervention.

The background of the Integral Eye Movement Therapy (IEMT) model

Integral Eye Movement Therapy (IEMT) is a therapeutic model developed in 2006 by the British psychotherapist Andrew T. Austin (Austin, 2007, 2015) aimed at dealing with and reducing intense negative emotional states. This model's origins can be traced back to Steve and Connirae Andreas's work regarding Eye-Movement Integration Therapy (Andreas, 1993) and Francine Shapiro's Eye Movement Desensitization and Reprocessing therapy (Shapiro, 1989). Also, another important aspect is the work on identity, using the exploration of pronouns, of New-Zeeland psychotherapist, David Grove (Wilson, 2017).

In short, this model involves recalling and maintaining a negative image of an event experienced in the past by the client, while the therapist guides his eye movements in different, but specific directions. The client is thus invited to concentrate his attention on the information asked by the therapist, while the therapist instructs the client to move their eyes in some specific directions by pointing them with a pen or with their finger. The outcome of the therapeutic process is usually the loss of the recalled image's emotional negative impact on the client's side. Also, another important aspect of the IEMT model resides in the fact that the client is not required to openly revealing or disclosing his/her problematic experience to the therapist. The IEMT model can also help identify the cause of the client's unwanted behavior and how to change it without having the therapist going through the client's past using specific therapeutic analysis techniques.

The main hypothesis underlying this therapeutic approach is based upon the fact that the eye movements in general can predict the client's recalled experience (Sharot, Davidson, Carson & Phelps, 2008) and that the specific set of eye movements used in the IEMT model is connected to areas of the brain that are in charge of memories and emotions, like the limbic system, the thalamus, the hippocampus, the hypothalamus and the amygdala (Austin, 2009a).

The IEMT model focuses on two major aspects, namely resolving the client's problematic emotional imprints through emotional engineering techniques and problematic identity aspects or patterns

through the use of identity re-imprinting techniques. Emotional engineering focuses on the emotional imprints regarding the client's unconscious and constant kinesthetic responses to certain types of experiences or stimuli from day to day life. Through the specific emotional engineering techniques, the IEMT model can identify how exactly the client did learn to feel in a certain way in a specific situation and how this can be changed to a more optimal and adaptive kinesthetic response. Identity re-imprinting focuses on the client's deeper identity imprints developed throughout his life and which are assessed to be problematic for his present wellbeing state. By using the specific re-imprinting techniques of the IEMT model, the therapist can assess and resolve the way that the client learned to be in a certain way in a certain context, or in his overall life.

After an IEMT based session, the client usually experiences the four following changes or improvements:

1. The visual image of the memory often becomes blurrier and loses its higher level of detail (Codispoti & De Cesarei, 2007; De Cesarei & Codispoti, 2008, 2010; Kringelbach, 2005).

2. The visual image of the memory furthers its distance in the mental representation of the client (Davis, Gross & Ochsner, 2011; Liberman & Förster, 2008).

3. The client experiences dissociation when the age progression takes place (Hossack & Bentall, 1996; Koziey & McLeod, 1987; Kross & Ayduk, 2011; Ventegodt, Kandel, Neikrug & Merric, 2005).

4. The client's level of emotional reaction concerning the initial problematic memory diminishes (Gray & Liotta, 2012; Muss, 1991, 2002; Struwig & van Breda, 2012).

Preliminary studies and detailed video recorded sessions have shown so far the efficiency of the IEMT model when dealing with issues such as long-term anxiety and PTSD related problems (Austin, 2010, 2014).

The Five Patterns of Chronicity

During his work as a therapist, Andrew T. Austin (Austin, 2009b, 2015) identified five primary patterns that clients with chronic issues would manifest as a recurring problem and, also, during the therapeutic process. Austin developed the IEMT model to address and resolve these five patterns of chronicity. While identifying one or more of these patterns during the therapeutic process, the therapist might provoke them in order to successfully work with them and to invite the client to reconnect with the ownership of his/her emotional states, beliefs and identity.

1. *The Three Stages Abreaction Process*. This pattern refers to the client's tendency to escalate the intensity of his negative emotions and expressed behavior during the therapeutic process, in order to generate behavioral change in his/her external close environment, including the therapist's. As the name implies, the pattern consists of three stages that make up a sequential process. The first stage is that of the "signal", in which the client implies to the therapist the threat of experiencing a negative emotion due to the therapist's behavior. The second stage refers to the "increased amplitude of the signal", in which the client threatens the therapist in a more direct way to change his/her behavior, putting more energy into his/her communication and displaying the physiological responses to the experienced emotional states. The third stage is that of the "abreaction" or of the "punishment", in which the client deliberately tries to punish the therapist for not changing his/her behavior accordingly, basically holding the therapist accountable for the consequences of his/her response to the latter's unchanged behavior.

2. *The "What if..." question*. This pattern refers to the client finding and using a counter-example, in most times hypothetical, in order to challenge, sabotage or counteract a therapeutic type of generalization. In this type of scenario, when the therapist proposes a technique during the therapeutic process, the client repeatedly expresses questions in the form of "Yes, but, what if…?". This type of pattern usually occurs when one or more of the client's beliefs are challenged by the therapist.

3. *The "maybe man phenomena"*. This pattern refers to a client who is uncertain of his/her own experiences or their intensity during the therapeutic process. A clearer example of this pattern would be in the situation in which the therapist asks the client for information regarding his experience, and the latter usually replies with answers such as "It's sort of…", "Perhaps…", "Maybe…", "I guess so…". The client, by maintaining and remaining uncertain or vague, will not commit to his/her own genuine or authentic experience or to his/her own identity and he/she will sabotage the therapeutic process, because the therapist cannot assess the actual information that can make a difference in the therapeutic outcome.

4. *Testing for evidence of the problem rather than testing for change*. This pattern is usually more common in clinical or psychiatric contexts, and refers to

the tendency of the client to identify any kind of evidence for the existence of the problem and ignoring any evidence of change or improvement. In this type of pattern, even if 99% improvement has been made during the therapeutic process, the client displaying this pattern will still be able to locate the still remaining 1% of the existing problem and will generalize it, thus perceiving it as being representative of 100% of the existing problematic aspect. To summarize this pattern, the client will display a confirmation bias, and focus his/her attention on any kind of still existing negative aspect of the problematic state, while ignoring any presence of improvement made during the therapeutic process.

5. Being "at effect" rather than "being at cause". This pattern revolves around the overall passivity of the client during the therapeutic process, in contrast to willing to be an active part alongside the therapist. A client being "at effect" experiences his/her emotional problems as happening to him/her rather than experiencing them as states or responses that he/she manifests or are being provoked or initiated by him/her. For example, a client being "at effect" will be seeking "treatment", while a person "being at cause" will seek "to change". Another example of a client displaying this type of pattern would be one who expresses "I have a voice in my head that tells me…" instead of "I think that…", or "I suffer panic attacks" instead of "I panic myself". By continuously manifesting this type of pattern, the client will not assume responsibility for his/her experiences and problems, thus complicating the overall therapeutic process.

Identity Processes (Exploration and Re-Imprinting)

Perhaps the aspect that sets the most apart the IEMT model from other therapeutic models that use eye-movements as major tool is the attention towards working with the identity level related issues of the client (Austin, 2014; Derks & Austin, 2013). The IEMT model focuses on how exactly the client learned to be in a certain way. In certain types of scenarios, people tend to adopt particular problematic emotional imprints such as "I feel anxious" to the identity imprinting level and generalize it as "I am an anxious person". This therapeutic model allows the therapist to bypass the beliefs supporting the undesirable aspects of the identity level such as "I cannot do this, because I am too anxious". More specifically, the IEMT intervention on the identity level emerged from David Grove's work on this matter (Dunbar, 2016), and explores four pronouns referring to the client's identity, namely: "I", "Me", "Self" and "You". A suitable example would be a situation in which a client says "I'm angry at myself". The IEMT trained therapist can explore the two pronouns "I" and "Self" and also the expression of anger experienced by the client through use of the specific methodology.

Unconscious eye movement deviation

Another important aspect that sets apart the IEMT model from other eye-movement-based therapies refers to the attention addressed to the client's unconscious eye-movements during the intervention (Austin, 2014). For example, when the therapist guides the client's eye movements in specific directions or areas, while simultaneously concentrating on the problematic memory, the client's directed eye movements may try to sidestep, lapse away or get around a particular area in that particular visual field. When this type of scenario occurs, the usual meaning is that the client's overall mental representation has changed to a different aspect of that problematic memory or to a specific moment in time in the client's life history. It is recommended that the therapist either: continues with the directed eye movements, tries to find other deviations in different directions or visual fields or stops the directed eye movements completely and recalibrates the client's specific experience.

Comparison of the IEMT model with the EMDR and the EMI models

Aside from the use of directed and specific eye movements shared by the IEMT with both Eye Movement Desensitization and Reprocessing – EMDR (Shapiro, 2001) and with Eye Movement Integration – EMI (Beaulieu, 2003), there are some significant differences that set it apart as a stand-alone therapeutic model. The first major distinction points out that the IEMT model emerged as a tool for addressing and resolving the clients' experiencing the "five patterns of chronicity" (Austin, 2014), while the EMDR and EMI model emerged as tools for resolving the client's trauma. The second major distinction is the attention addressed by the IEMT model to the identity level, namely the imprints that made the client learn to be the way he is at present (Austin, 2009a).

II. Method

The present case study is part of the Association for IEMT Practitioners' Psoriasis Research Project, "Preliminary Trial for Research Study of IEMT Application to Psoriasis", supervised by Andrew T. Austin, the developer of the IEMT model, and Joanna Harper, IEMT certified Trainer (Austin & Harper, 2017).

The clients filled in and signed a consent form; the therapist also collected the clients' history, and created a form to assess the current psoriasis state experienced by the client. Also, the therapist introduced what the IEMT model is and how it has proven to be effective in the treatment of psoriasis, in a less technical way (Austin & Harper, 2017).

For this case study, the primary techniques used are the IEMT "Basic Pattern", regarding the client's symptoms, and the IEMT "Identity Re-imprint", for exploring psoriasis as an anthropomorphized identity, as recommended by Austin & Harper (2017).

The IEMT Basic Pattern

The following pattern is the standard procedure when using the IEMT model on the client's problem for the first time, and it is has shown to be the most successful technique so far. This pattern is outlined below, as described by Austin (2009a):

1. An IEMT-based session starts by the therapist eliciting the client's current undesired state or kinesthetic experience. This is made by asking the client the following three questions in this exact order:

1a. *"…and out of 10, how strong is this feeling, with ten being as strong as it can be?"*. By asking this question, the client can assign an amplitude scale for the current undesired state or kinesthetic experience (from 1 to 10).

1b. *"…and how familiar is this feeling?".* By asking this question, the therapist can assess the client's degree of familiarity with the current undesired state or kinesthetic experience.

1c. *"...and when was the first time that you can remember having this feeling… Now, it may not be the first time it ever happened, but rather the first time that you can remember now…"*. By asking this question, the therapist can help the client identify the experience that triggered his/her current undesired state or kinesthetic experience.

2. The client is then given around 20 to 40 seconds to access the imprinting event of the current undesired state or kinesthetic experience. The therapist does not offer any kind of guidance or advice, but he allows the client to solely perform his/her own kinesthetic transderivational search.

3a. After the client has accessed his/her earliest recollection of the problematic feeling, he/she is asked by the therapist *"...and how vivid is this memory now?"*

3b. The client is then instructed to access the memory and associate with it: *"hold this memory vividly in your mind for as long as possible…"*

4a. The client is then guided by the therapist to perform specific eye movements through different axis and access points while he/she continuously accesses the recalled memory identified above. Also, if necessary, the therapist periodically reminds the client to access that specific memory: *"…and if this memory fades, try very hard to bring it back… try as hard as you can to retain that experience…"*

4b. The therapist repeats the above process in sessions of maximum 40 seconds, until the client protests that he/she can no longer retain or recall the specific visual memory of the event.

5. After the client concludes that he/she can no longer retain or recall the specific visual memory of the event, the therapist tests the evidences for change. This step is done by consecutively asking the following two questions: *"...and how does that memory feel now…?"* and

"…and what happens when you try access that feeling now?". In the case that the imprinting event is still triggering negative kinesthetic experiences for the client, the therapist repeats the above process.

6. If the process has to be repeated for the imprinting event, the therapist will have to re-test the evidence of change by directly asking the client about the anticipatory event that triggered the undesired kinesthetic experience: *"...and when you think about <anticipatory event> presently, what feeling comes up for you now?"*. In the case that negative kinesthetic experiences still emerge, then the entire above basic process is repeated and new imprints are identified, located and worked with.

Identity re-imprinting

The following pattern represents the basis when working with the IEMT model on the client's problematic identity issues. This pattern of the identity re-imprinting process has two major phases and is outlined below as described by Austin (2009a):

1. Elicitation of the client's identity components using a series of questions based on the client's use of the pronouns "I", "Me", "Self" and "You". For example, when the client uses the "I" pronoun in a sentence such as "I hate myself", the therapist explores this pronoun with the three following sequential questions:

1a. *"...and when you think 'I', where about is 'I'?"*

1b. *"…and how old is that 'I'?"*

1c. *"…and what is happening around that <age in years> 'I'?"*

In some cases, the client can ask for clarification regarding the third question, but the therapist is encouraged to not offer any kind of guidance, but, instead, to repeat the question if needed.

The same sequence of questions is repeated for the pronouns "Me", "Self" and "You", if the client uses them in a certain affirmation about his/her own identity.

2. Intervention on the client's identity components using specific eye movements:

In many cases at least one identity aspect may be problematic for the client. In the above examples where the client might state "I hate myself", both the "I" component and the "Self" component may need intervention. In this case, the "I" component may have a problem with "hate" towards other people and the "Self" component may have a problematic aspect regarding self-confidence, etc.

The therapist instructs the client to recall and maintain the image identified when asked *"What is happening around that 'I'?"* and guide the movement of his eyes around the "lazy 8" pattern for six times, both clockwise and anticlockwise and then to recalibrate. The same process is repeated for the pronouns "Me", "Self" and "You", if they have been identified as being problematic.

III. Case study

The case of Richard

The participant in this study, whom, for the rules of anonymity in psychological research, we will call "Richard", is a male of 49 years and his current occupation is that of self-employed electrician (more specifically he is involved in organizing music events and rock concerts). He has two children, of 4 and 10 years old, resulted from relationships with two different partners. Prior to 2009, Richard has never suffered from head injury or other types of concussions, nor has he ever received in-patient psychiatric treatment.

The first problematic aspect occurred in 2009, when Richard had his first epileptic seizure while driving his car. After this event he was prescribed Epilim, but after a month of treatment he did not respond well to this medicine and the treatment was changed to Levetiracetam-lupin (this type of medication would be discontinued in the UK beginning with 19th July 2017), a fairly low dose of 1000mg, consisting of 2 tablets a day. Following this treatment, he stopped having epileptic seizures for the next 3 years and a half.

However, in 2013 he started to experience again epileptic seizures and followed a once-a-week acupuncture treatment in order to alleviate his stress levels.

Following this, in the first quarter of 2015, Richard experienced 4 more epileptic seizures. He was still taking Levetiracetam-lupin, but was also using alcohol and marijuana in the evenings in order to help him get to sleep.

Finally, in August 2015, Richard first noticed a skin complaint when a red blotch on his torso appeared, this started off on a small portion of his skin but by the end of September 2015, it had covered most of the right side of his body and also appeared across his left shoulder.

Session no. 1 – assessment

On the 25th of February 2016, Richard first contacted the therapist and on the 2nd of March the same year, a first one to one 90-minutes diagnosis session followed. The client was presented with the IEMT process and research project, he filled in and signed an informed consent form, and an assessment form was completed so that his case history was first fully documented, as described by Austin & Harper (2017). Richard agreed that his current diagnosis and all the content of the therapeutic process be documented (including photographs and transcripts) and be published at a later stage, as long as his identity would not be revealed. Also, his psoriasis related eruptions were photographed and measured using tape measure (see Figures 1 & 2) in order to mark the initial state in which he arrived at the beginning of the IEMT treatment.

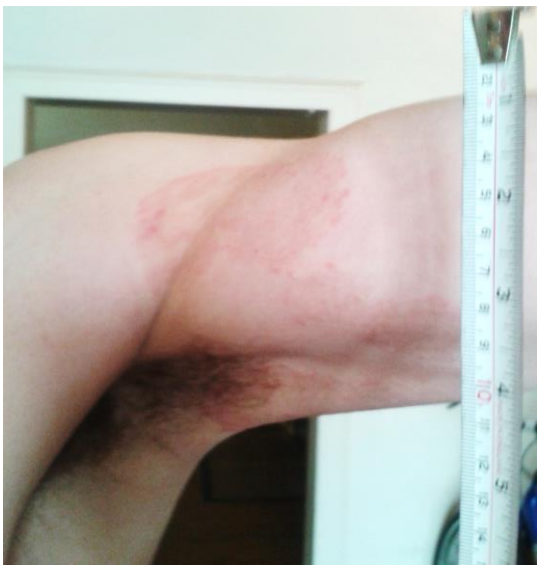

Figure 1 – psoriasis-induced eruption on Richard's arm before the IEMT-based treatment session

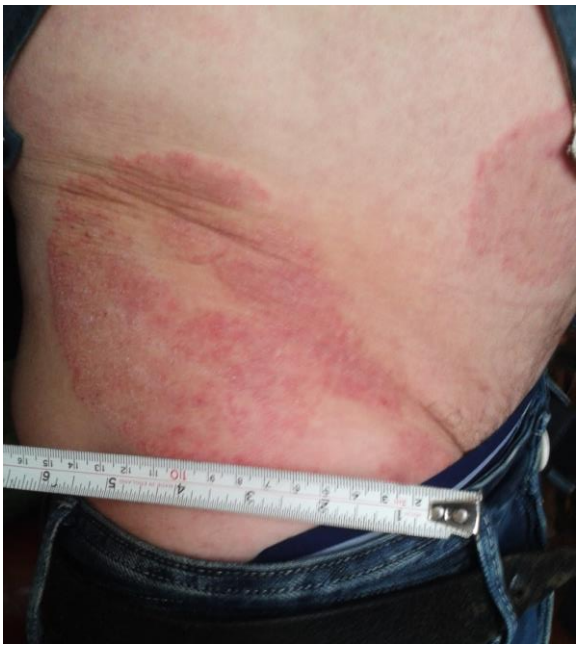

Figure 2 - psoriasis-induced eruption on Richard's hip before the IEMT-based treatment session

Another very important aspect is the research made by the therapist for any possible contraindications with his current medication treatment. He also advised Richard to reduce the amount of marijuana and alcohol intake, in order for the following IEMT session to take place and also to increase the chance for a successful outcome.

Session no. 2 – treatment

On the 8th of March 2016, the first IEMT proper one-to-one session took place, and it lasted for 2 hours and 15 minutes. The psoriasis eruptions were again measured and no significant (worsened or improved) changes occurred. Also, Richard had started using a non-prescription steroid based cream on the psoriasis-induced eruptions but with no results whatsoever.

At the beginning of the session, the side effects of mixing alcohol and marijuana with his prescribed medication were discussed and the therapist learned that, since taking Epilim, Richard's waistline had rapidly increased and the most problematic aspect reported were the bouts of intolerable itching that he was experiencing. However, the first signs of psoriasis did not appear until August 2015, which was over 6 years later since taking the Epilim-based treatment.

As described earlier, according to the design of the IEMT-based process for the research, the therapist asked Richard about any traumatic events in his history, more specifically, if he could remember a time in his past that he considered to be life threatening, or something that was so traumatic that he thought he might not survive it. Also, the therapist informed him that he personally didn't really need to know the content but rather the feeling of how that was for him at the time.

Richard immediately told a story from when he was 32 years old. He was living at that time in Amsterdam, The Netherlands, and then one night in the early hours of the morning he was awoken to find 2 burglars in his apartment. They attacked him and started to ransack through his possessions.

His memory of the attack was a clear imprint and very detailed, he said it was if *"Time came to an almost standstill"*. He also said he needed to *"Run for his life"* because he felt vulnerable and helpless to do anything about it. From this, it would appear that this single traumatic incident may lead us to the "lynch-pin" aspect. This was the trigger that the therapist was looking for in order to start working from. Also, the therapist asked Richard if he had suffered any issues prior to this event happening. Richard replied that before this happened he was perfectly fit, with no known mental or physical problems.

Next, the therapist asked Richard to recall the first time he felt vulnerable and helpless: *"When was the first time you can remember feeling vulnerable and helpless? Now, it may not be the first time it ever happened, but rather the first time you can remember this now."*

It is important to note that this is a specific type of question that is designed with 2 embedded commands; these assist the client to bring the memory into his conscious awareness:

1) *"You can remember feeling vulnerable and helpless now"*,

2) *"You can remember this now"*.

This was the first question in the IEMT process which prompted him to engage with the emotional imprint. Richard replied to this question by recalling to being stranded as a child in the park when he went to the zoo. He said that this was the first time he had the feeling of being vulnerable and helpless.

The therapist then asked him: *"How vivid was the memory of this image of being vulnerable and helpless?"* by giving a score on a scale of 1 to 10: *"Can you give me a scale of 1 to 10?"*. Richard, instead of giving a number to mark the intensity of the vividness of the image, answered with *"It's high."* The therapist insisted on this aspect and asked him again: *"Do you have a number from 1 to 10?"* This time, Richard replied with: *"Yeah, it's a 9 or 10."* and the therapist asked: *"Well, is it a 9 or is it a 10?"* Being confronted with this

dichotomous type of question, Richard finally answered in a more specific way, replying with: *"It's 10."*, thus assessing the vividness of the recalled image at an intensity of "10".

The above paragraph is a very clear description of a pattern of chronicity referred to as the "maybe man phenomena" and discussed in more detail in the 'Introduction' section of this article. This pattern emerges when the client is not truly engaging into their experience of the event so they become vague and will often give an answer as if it was a question. This can easily be missed by the less observant therapist, but nevertheless this is something to be watch out for during the therapeutic process.

Afterwards, the therapist then requested that he hold this image of feeling stranded in his mind then open his eyes then follow his finger. Then the therapist moved his eyes across the 6 axis points while watching for any saccades and any breaks in the smooth eye movements. Non-saccades were also noted.

The eye movements were very smooth, as the therapist continued to say: *"If this image starts to fade away, then try to bring it back."*, all the while getting him to focus specifically on his moving fingertip.

It is also important to note that one's attention can only ever actually focus on one thing at a time, so 'trying' to hold this image in the client's mind while simultaneously remaining focused on the therapist's moving finger is an intentional set up for him to fail. It's at this point where resources are built into the problem state because he fails to recall the traumatic memory. This is because no matter how hard he tries, he cannot pay attention to two things at the same time. The image of him feeling vulnerable and helpless faded away, and with this the emotional imprint that was coupled to it also faded away.

The therapist tested this by asking Richard: *"What happens now when you try to bring it back?"* Richard replied that he could remember the event but the feeling associated with that past event had changed. He also scored the intensity at a level of *"4 out of 10"*, a clear indication that a change had taken place, as previously it was at a level of intensity of *"10"*.

By this time, 60 minutes of the session had passed, so the therapist and Richard agreed to call for a break. However, although Richard believed that the session was paused the therapist invited him to keep chatting; while the therapist kept track of his language to listen for changes in the way he talks about past events. The therapist also used this time-out to reinforce that change will occur after the session.

After the break, the session continued and the therapist shifted back to recall the Amsterdam event and asked if there were any prior events when he may have felt traumatized. Richard reported he was also physically attacked when he was 24 years old, in a bar in Ibiza, Spain. He was jumped and repeatedly hit over the head with bottles. He was taken to the hospital and patched up. However, he didn't feel as this was life threatening and assessed the event memory as *"6 out of 10"* for vividness or intensity.

Again, the therapist worked through the IEMT process and then tested for change. After the completion of the process the intensity of the image was reduced to *"2 out of 10"*. The therapist used the intensity feeling of *"2"* to explore if he had any associated feeling to work on, but no associated feeling came to Richard's mind.

The therapist then switched Richard to think of day to day activities, in order to explore if he could identify any other issues that were triggering his psoriasis-induced eruptions. Aside from the day to day trials, of time sharing with his two children, the bills which he needed to pay and not having a vehicle to get to jobs because of the epilepsy seizures history, the therapist could not identify any other traumatic events to explore.

In the end, the therapist and Richard mutually agreed to end the session and have a follow up a few weeks later.

Follow-up

On the 23rd of March 2016, the therapist telephoned Richard to check on his progress and he reported that the psoriasis-induced eruptions were almost gone. Again, the therapist followed up 2 weeks later and Richard reported that there were no signs of any psoriasis.

Following this, 3 months later, the therapist also checked in with Richard and he did not report any kind of signs or reoccurrence of the psoriasis-induced eruptions. Also, the therapist asked Richard if he would take some photos for publishing and email them, which he gladly did, and you can see them below in Figures 3 and 4.

On the 17th of August 2018 (2 years later), the therapist once again contacted Richard on the telephone and he reported to not having had any further psoriasis-induced eruptions (see Figures 5 and 6) and neither any more epileptic seizures.

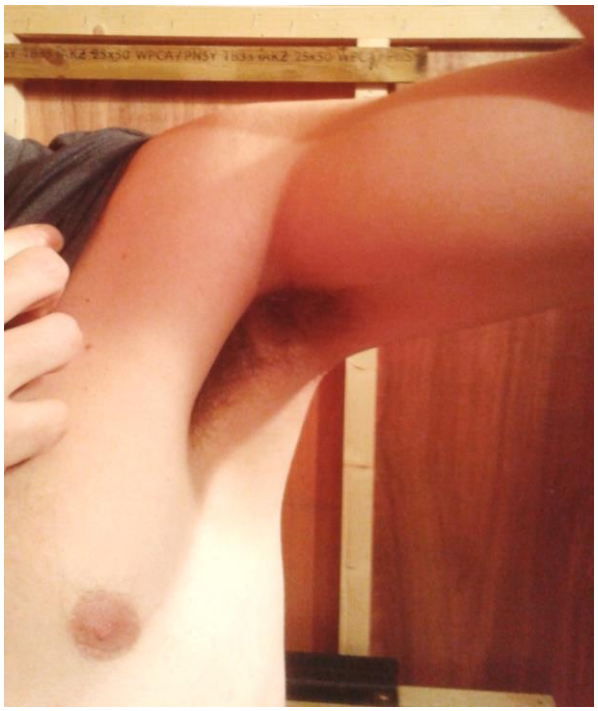

Figure 3 – Richard's progress on his psoriasis-induced eruption in the arm area 3 months after the IEMT-based treatment session

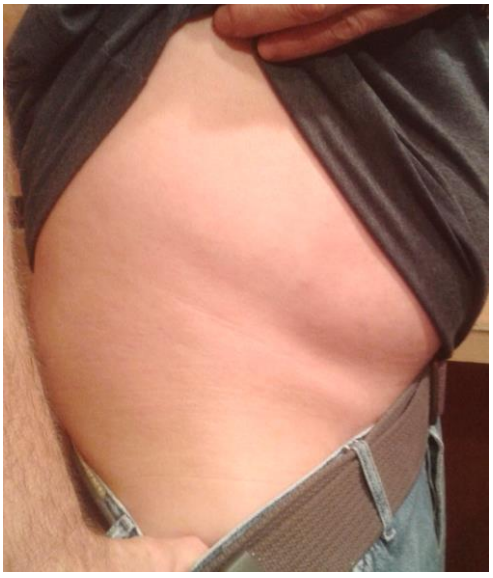

Figure 4 - Richard's progress on his psoriasis-induced eruption in the hip area 3 months after the IEMT-based treatment session

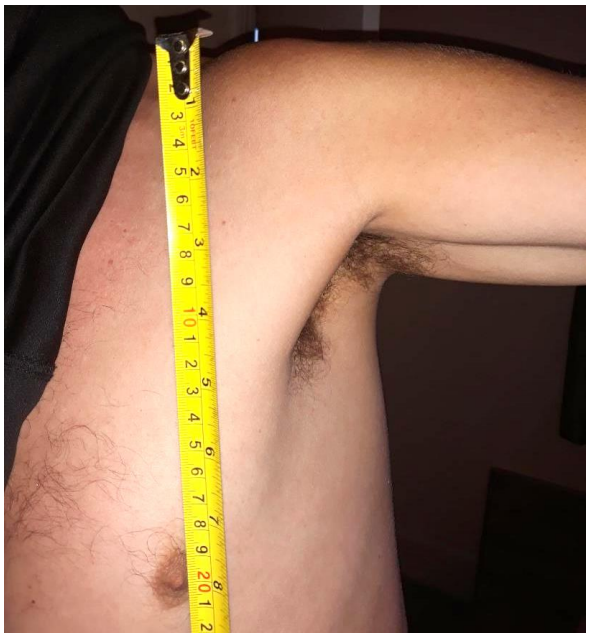

Figure 5 – Richard's progress on his psoriasis-induced eruption in the arm area 2 years and a half after the IEMT-based treatment session

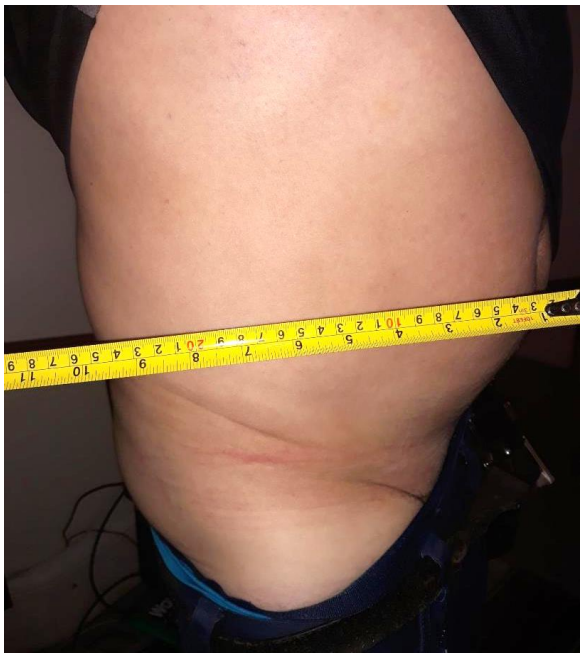

Figure 6 - Richard's progress on his psoriasis-induced eruption in the hip area 2 years and a half after the IEMT-based treatment session

IV. Results

The client, named "Richard" in this article for reasons of protecting his identity, reported that two weeks following the IEMT based treatment session, the psoriasis-induced eruptions started fading away.

Following another two weeks, Richard reported that there were no signs of any psoriasis psoriasis-induced eruptions, and three months later, the results have been stabilized, with no signs of reoccurrence.

In August 2018, more than two years after the IEMT based treatment session, Richard reported that he has not had any further psoriasis-induced eruptions since then and neither has he experienced any more epileptic seizures.

V. Discussion

The case study outlined above has shown promising results in treating psoriasis with the rather new Integral Eye Movement Therapy model. Also, another surprising positive side-effect was the lack of client's additional epileptic seizures which have not reoccurred since the IEMT based treatment session.

This case study also confirms the research conducted by Gupta & Gupta (2002), regarding the use of the EMDR-based approach in treating stress induced psoriasis, and shows that eye-movement based therapies can become valid and significantly wide-spread complementary approaches in treating this type of issue.

VI. Conclusions

The Integral Eye Movement Therapy model is a type of brief and non-intrusive therapy and a currently rapidly evolving field that provides the means for a core state change in a minimal time-frame.

Although the results are quite promising for treating stress or traumatic induced psoriasis and maybe epileptic seizures with the IEMT model, we have to take into account that this paper describes only a single case, in which many other factors might have had a very important influence. One important factor might be the client's quitting of alcohol and marijuana consumption.

As we stated above, this case study is a first documented one from the larger research project initiated by the Association for IEMT Practitioners, investigating the treatment of the IEMT process as a possible alternative treatment to psoriasis (Austin, T. A. & Harper, J., 2017) and further research on the Integral Eye Movement Therapy model, as well as on other eye-movement based therapeutic approaches, in regards to their use in the treatment of psoriasis and also in other stress-related aspects, are needed and will surely follow in the near future.

Acknowledgements

We would like to thank Steve Andreas, Andrew T. Austin, James Lawley and Richard M. Gray for their kind support and for providing us with all the needed academic resources in writing this article.

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