

The Reintegrative Protocol™

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The Reintegrative Protocol™ is a trauma treatment approach which uses the same method, regardless of the client's gender or sexuality, since its aim is to facilitate the resolution of trauma. However, clients often report spontaneous sexuality change as a byproduct of the protocol's repeated use. This paper will specifically examine the protocol's application within the context of treating males presenting with same-sex attractions and will provide instructions for using self-compassion as a method of trauma resolution, as well as optional instructions for EMDR-trained psychotherapists who wish to use EMDR as a method of trauma resolution.

Introduction

The Reintegrative Protocol™ is a versatile clinical trauma treatment for males and females, regardless of their sexuality. In the following example I will specifically illustrate how the Reintegrative Protocol™ would be applied to males with same-sex attractions they wish to explore and will include optional EMDR instructions for therapists qualified to use EMDR therapy. Therapists not trained in EMDR therapy may use the mindful self-compassion version of this protocol.

A substantial volume of empirical evidence supports the psychological benefits of mindful self-compassion, for example its demonstrated safety and efficacy in the

treatment of a variety of clinical symptoms, particularly in mitigating negative responses to unpleasant events (Leary, Tate, Adams, Allen, & Hancock, 2007), the association between childhood maltreatment and subsequent emotional regulation difficulties, and problem substance use (Vettese, Dyer, Li, & Wekerle, 2011). It is also linked with increased psychological well-being (Neff, Kirkpatrick, & Rude, 2007).

A growing body of empirical research also supports the safety and efficacy of EMDR therapy for resolving a variety of clinical disorders. Twenty-four randomized controlled trials now support the positive effects of EMDR therapy in the treatment of emotional trauma and other adverse life experiences relevant to

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clinical practice (Shapiro, 2014) and the American Psychiatric Association has recommended EMDR therapy for many patients (APA, 2004). EMDR therapy is widely viewed as an integrative approach with other therapeutic modalities (Shapiro, 2002). According to EMDR therapy, overwhelming, dysregulating experiences in the client's life disrupt the ability of the client's nervous system to adaptively process, encode and store information related to the traumatic event, leading to the client's trauma-induced irrational maladaptive negative cognitions, propensity toward addictions and other PTSD symptoms (Shapiro & Forrest, 1997). The systematic implementation of bilateral stimulation (most commonly administered through bilateral eye movements) is believed to contribute to the client's adaptive reprocessing of these traumatic events, and as a result, the client's negative cognitions, propensity toward addiction and other PTSD symptoms often resolve (Shapiro & Forrest).

With proper EMDR therapy, changes in the client's affects and cognitions are common, with no ideological influence from the therapist. For example, a therapist believing the client's fear of heights is irrational never needs to argue with or in any way coerce the client into the therapist's own belief about what heights constitute a danger to the client. In proper EMDR therapy, rather than debate with the client about whether his fear of heights is appropriate or not, this topic can be bypassed by allowing the client to reach his own conclusions as the trauma-induced components of the client's memories and triggers resolve—any fears which remain after the reprocessing are considered ecologically sound. Examples of this were noticed by the creator of EMDR therapy, Francine Shapiro, when she noted that.... “EMDR would not desensitize a person's negative feelings if they were

appropriate to the situation” (Shapiro & Forrest, 1997, p. 25). Adaptive affects, such as fear about being too close to a cliff remained, while inappropriate, maladaptive affects (for example, the feeling of terror induced by simply being exposed to the word “cliff”) spontaneously dissolved.

This method of reprocessing is of great significance when the client and therapist discuss such an important topic as sexuality. Religion, societal pressure, self-image and health concerns all come into play.

Reintegrative Therapy® as distinct from so-called “conversion therapy”

When some individuals hear how Reintegrative Therapy® can lead to changes in clients' sexuality, they sometimes assume it is a so-called “conversion therapy”—a broad, ill-defined term used to describe efforts that “seek to change an individual's sexual orientation” (see S.B. 1172, 2011-2012). Reintegrative Therapy® itself and this protocol are categorically separate from “conversion therapy” or “sexual orientation change efforts” (SOCE) for several reasons.

First, Reintegrative Therapy® treats trauma and addictions. Changes in sexuality are a byproduct, not the goal. As a consequence, Reintegrative Therapy®, and the Reintegrative Therapy Association (a 501(C)3 non-profit organization) take no stance as to whether homosexuality should be considered a mental disorder. Second, Reintegrative Therapy® methods are used with no modifications related to the clients' or therapists' gender or sexual orientation. Providing a client with same-sex attractions the exact same protocol as a client with heterosexual attractions helps bypass the complicated ethical and religious “landmines” related to the religiously and politically charged

topic of sexuality. The client is free to come to his own conclusions about his sexuality. No ideological dogma by the therapist needs to be introduced in order for the protocol to work.

Third, Reintegrative Therapy® employs only established, evidence-based treatment approaches (such as mindful self-compassion and EMDR), the same approaches used by other clinics throughout the world that seek to treat trauma (as opposed to “conversion therapies” which seek to change sexual orientation).

Avoiding the pitfalls of “conversion therapy”

The Reconciliation and Growth Project (see ReconciliationAndGrowth.org/guidelines), an organization of mental health professionals and academics from diverse sexual identity and religious backgrounds, seeks to foster “dialogue among people with differing perspectives on faith-based values and sexual and gender diversity.” Among them is Lee Beckstead, Ph.D., a member of the APA’s Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The organization highlights four specific interventions they consider to be inherently unethical and potentially harmful when addressing sexuality, gender and faith:

1. Fostering expectations of a specific sexual orientation or gender identity outcome
2. Using direct or indirect coercion
3. Basing interventions on bias, unfounded theories, or prejudice
4. Limiting the exploration of sexual orientation, gender and faith identity and expression possibilities

Though Reintegrative Therapy® is a sexual orientation-neutral approach which employs identical methods for males and

females regardless of the client’s sexual orientation, male clients with same-sex attractions have reported decreases in their same-sex attractions and, for some clients, increases in their heterosexual attractions as a spontaneous byproduct of its use, so this particular article will illustrate the protocol’s use when applied to a male in this population.

The Reintegrative Protocol™, when properly applied, allows both client and therapist to bypass every one of the four ethical problems which may arise in “conversion therapy.” The client and therapist do not need to try to change the client’s attractions—the protocol involves exploring the client’s attractions from a neutral stance of curiosity and then seeking to resolve the trauma memories which lie beneath with standard trauma treatments. The use of a treatment protocol means the client and therapist do not need to adhere to any particular ideology or causal model about sexuality, nor do they have to posit any particular moral, political or religious stance on the topic. The protocol-driven approach reduces and can even eliminate the therapists’ ideological influence in the client’s treatment.

The Reintegrative Protocol™’s four-phase approach consists of history and evaluation, preparation, assessment, and reintegration. After describing the steps involved in each phase, I conclude this article with some theoretical discussion of the protocol’s approach.

Phase 1: History and Evaluation

1. Obtain history, frequency and context of the client’s symptoms (for behavioral addictions, this is the addictive behavior).
2. Evaluate the client for safety factors that determine whether he has the coping skills and integrative capacity to manage potentially

high levels of negative feelings. If the client is too fragile for trauma or addiction work, supportive psychotherapy and instruction in calming and stabilization skills would be in order until the individual is prepared for more direct and challenging psychotherapeutic work, such as this protocol.

Phase 2: Preparation

3. Explain the Reintegrative Protocol™ and how complex emotions can sometimes lie beneath our traumas and addictions, and how self-compassion can help with their resolution. If EMDR therapy may be appropriate, information about EMDR therapy for processing disturbing memories can be provided.

Phase 3: Assessment

4. Identify the specific element of the target behavior that has the most emotional intensity associated with it. For sexual behaviors, this would be the peak moment of the client's most powerful sexual fantasy (Figure 1).

The therapist would inquire:

"Tell me about the sexual fantasy or experience that you want to work on. Tell me about it in as much detail as you're willing to give me."

The client may respond:

"This ideal man performs oral sex on me, as he praises me." or, "I'm having sex with two men I've just met. Their only desire is to meet my every need."

5. Identify the specific feelings associated with the most powerful moment of the sexual experience and allow the client to experience this feeling as intensely as he can. Time must be taken for him to carefully identify the feeling he gets from this (i.e., *powerful, bonded, worthy, wanted*, for example). It is very important that he knows his therapist is accepting of him so that he can enter the sexual trance state during this moment, and it is crucial that the therapist be truly accepting of this part of his client. If the client is vague or unable to discuss his sexual fantasy or his feelings associated with it, this is likely an indicator of significant client shame. In order for the client to make productive use of this protocol, he must

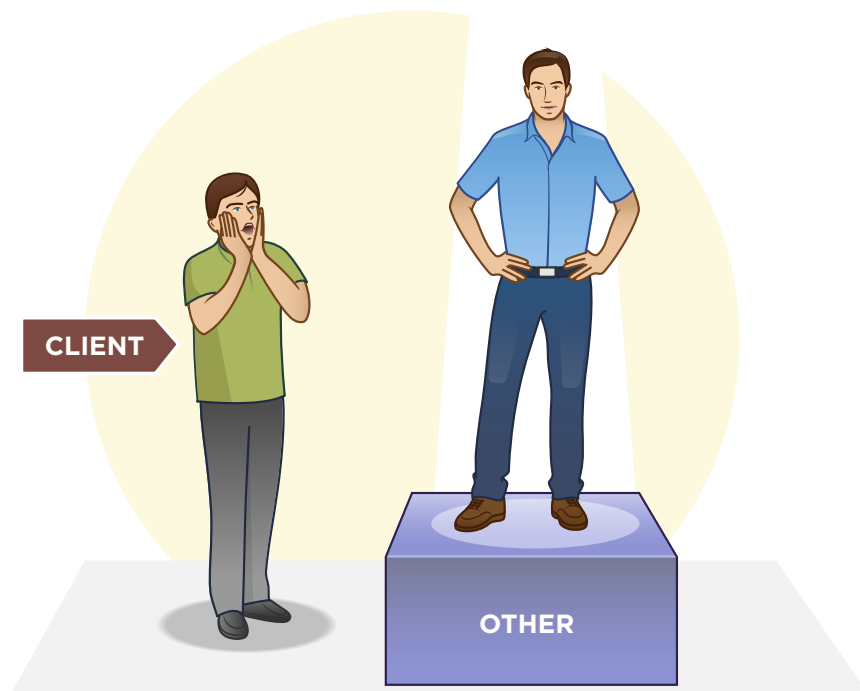


Fig. 1 Examining activating event.

be able to join the therapist in maintaining a mindful stance of openness, acceptance and curiosity about his sexual thoughts and feelings. Therefore, the therapist may need to spend extra time, even several sessions if necessary, in this phase of the protocol, both modeling for the client and supporting him in developing understanding and non-judgmental curiosity about his sexual fantasy and the feelings he associates with it. Sexual abuse victims often have difficulty with this if their sexual fantasy relates to an abuse memory, so it can often be helpful to provide psychological education about how complex, conflicting feelings often emerge after a trusted caregiver becomes sexually abusive.

6. Once the client is visualizing the peak moment of his sexual fantasy and allowing himself to intensely experience its associated emotion, ask the client to imagine taking a stance of being outside of himself in the third person and look deeply and directly into his own eyes and notice what he sees (Figure 2).

Therapist:

“Go outside of yourself in the third person and look in at yourself, directly into your own eyes. Take your time and just notice what you see in him [speaking as if the client’s eyes were in the third person].”

The therapist must be careful to move slowly at this point, asking open-ended questions if needed. It is crucial that the client is allowed to come to his own conclusions, at the pace that works for him. This is not a time for analysis or interpretation of his answers. As the client imagines being outside of himself and peering steadily into his own eyes, exploring what affects are inside, his only job is to “let whatever happens, happen” (Shapiro, 2002, p. 38) with no moral judgment or pressure from the therapist as to what he should see.

The therapist may need to gently and repeatedly draw the client’s attention back to the visualization of looking deeply into the

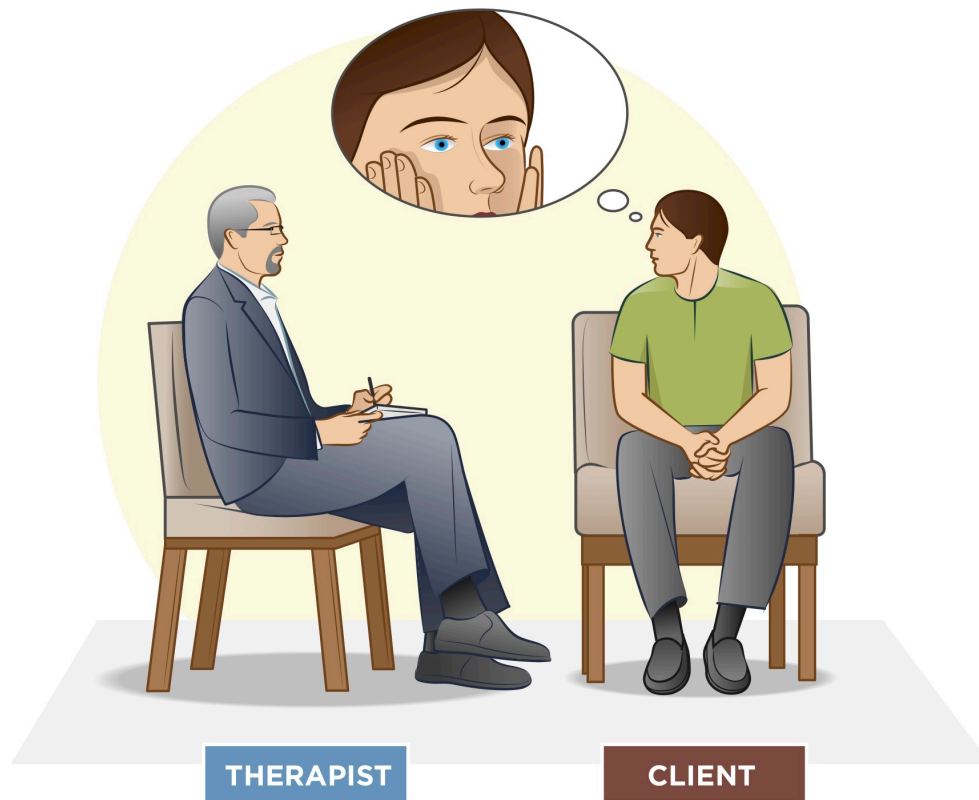


Fig. 2 Identifying and acknowledging the associated feelings.

client's own eyes to help the client maintain that gaze. The therapist must be steadfast in gently guiding the client back to peering deeply into his own eyes. With a stance of openness, curiosity and gentleness, the therapist may inquire:

What are you seeing in his eyes...?

What do you think he's wanting...?

What do you think he's hoping he'll get from this...?

What feeling do you see behind the feeling you just mentioned..."

The client's awareness of his emotional motivations likely presents itself in a specific order: (1) sexual fantasy trance, (2) underlying emotional desire (craving) and (3) the originating unmet need which is the result of the individual's early emotional trauma and experiences of neglect (Figure 3).

7. Once the client is able to see and experience the originating unmet need, ask him to associate back to an earlier memory from the third-person perspective (Figure 4).

Therapist:

What's an earlier time he's felt this way...? What happened in his life that caused him to feel this way in the first place...?

The client will likely associate an important memory which relates to his unmet emotional need:

"I'm alone on the playground, and everyone is ignoring me. Or, "I remember my mom shouting at me, and I was afraid of her."

Spontaneous associations to childhood memories often occur with no prompting from the therapist, particularly with clients who have used this protocol with their therapists several times.

If memories are identified, the therapist has a choice point: he or she can now shift directly into EMDR therapy phase three (assessment) by identifying the images, negative cognitions, positive cognitions, etc.,

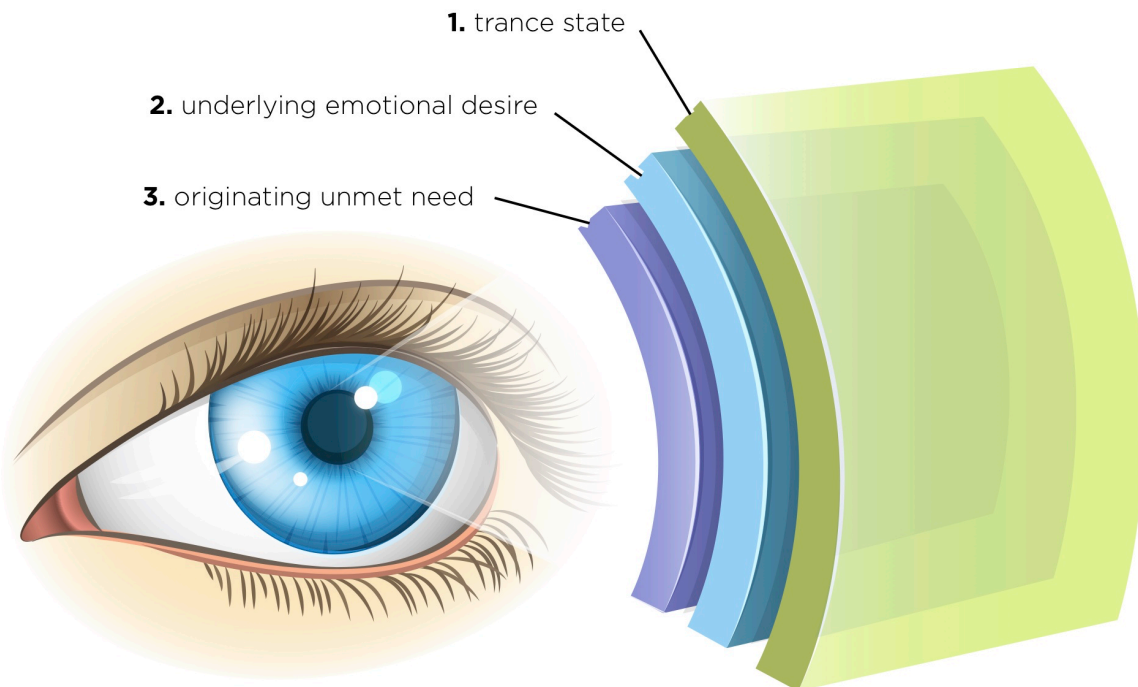


Fig. 3 Transcending the trance state through gaze inversion.

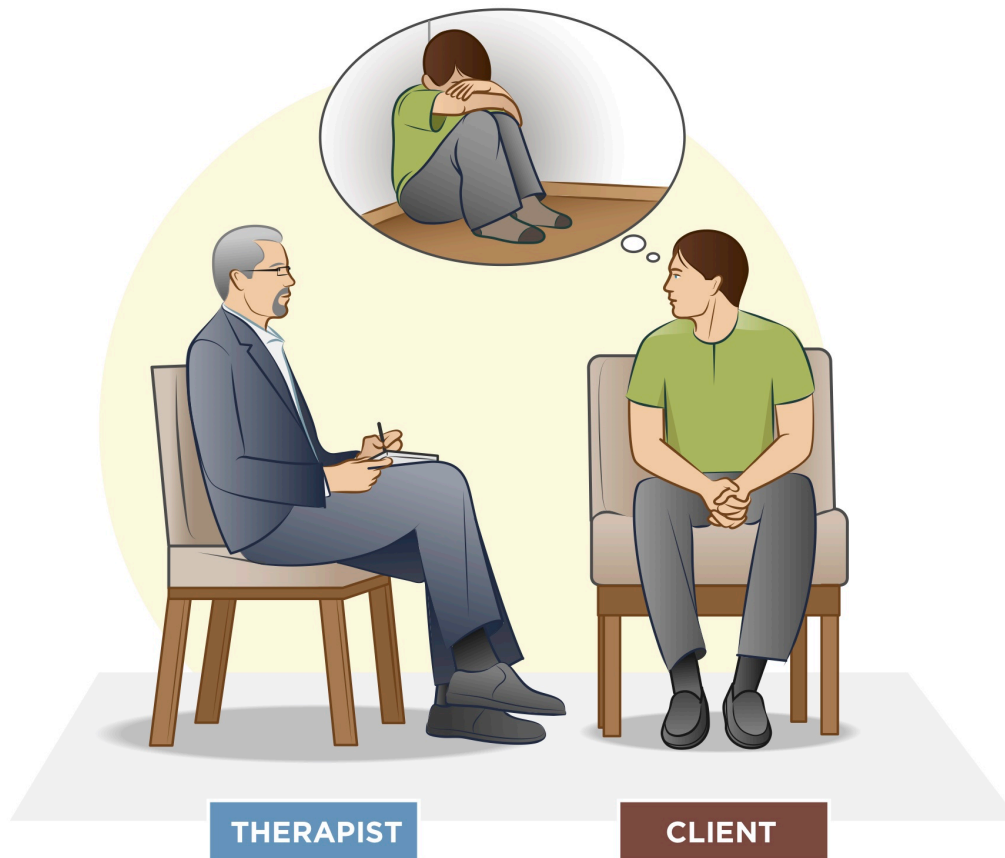


Fig. 4 Associating back to historical experiences.

and then continue to phases 4-7 for memory reprocessing. For EMDR trained therapists, the following steps of this protocol are not needed, since the therapist may continue from this point with EMDR therapy's standard protocol. If EMDR therapy is not suitable, then continue with the following steps (below) and use mindful self-compassion to process the trauma(s) instead of switching to the EMDR standard protocol.

Phase 4: Reintegration

8. Once the client has identified the earlier trauma memory, begin to resolve it using mindful self-compassion. At this point, the therapist asks the client, who is still in the third-person observer state, to access feelings within himself of compassion toward his younger self (Figure 5):

“Look deeply into the eyes of your younger self. Can you see the need in him?”

“If you take in a deep breath and open your heart toward him, look directly into his eyes. What do you feel inside yourself when you see his unmet needs?”

As the client gains access to his own feelings of care and compassion, the therapist then encourages him to express that compassion toward his younger self:

“If that feeling inside you could express itself toward him, what would you do or say?”

For some clients who have difficulty accessing feelings of compassion, this difficulty can often be remedied by the therapist asking the client how he would treat his own child in that moment:

“Look deeply into his eyes. If you had a son whom you really loved... and that child was in this situation, how would



Fig. 5 Feeling and expressing self-compassion.

you feel toward him? How would you feel if you really opened your heart toward your child in that moment?"

The client may initially report feeling overwhelmed by the pain of the child, stating that he cannot possibly give the child what he needs. This objection is typically voiced by clients who have low self-worth, believing they have little of value to offer others. This roadblock is easily addressed with brief education and encouragement from the therapist. The client needs to be taught that, although children can be easily hurt, they can also be easily reassured with a small amount of compassion from a benevolent caregiver. The therapist can continue:

"See if you can offer him (the client's younger self) the compassion that you do have. You don't have to solve all of his problems right now, and you'll be surprised how far your care will go for him."

Once the client is able to access this sense of care and compassion and openness to-

ward his imagined child, the therapist can ask him to now express this toward his younger self:

"If that feeling there in your heart felt really free to express itself in that moment, what would you say or do toward your younger self?"

Clients typically are moved to care for their younger selves, holding, guiding and listening. As his younger self (which holds onto the original unmet needs) is cared for, brought close and "reintegrated" with the observing, caring adult self, the therapist might facilitate this process by asking the client:

"In that moment, look deeply into the eyes of your younger self. What does he know about himself in that moment...? What does he know about you in that moment...?"

Clients who are able to feel and express their compassion toward their younger selves in the memory will often respond by saying something like:

“He knows he’s acceptable,” and “he knows I’ll always be there for him.”

The development of self-compassion can sometimes require frequent intentional efforts. This is something the ancient tradition of mindfulness has taught us.

9. Ask the client to go back to the original sexual fantasy or memory identified in phase 3. Therapist:

“What is your emotional reaction to this original scene now?”

What do you know about it now, that you didn’t when we began?

What do you think is the connection between the sexual fantasy and the memory we worked on?”

By this point, the client has very likely lost his sense of unrealistic idealization of the other person in the fantasy, lost his shame about himself for having the sexual desire in the first place, and gained insight into the true motivations behind his sexual feelings and

behaviors. He likely experiences himself and the other person as equals and is less likely to experience the original sexual fantasy/memory as affectively dysregulating (Figure 6).

Discussion

Clients who have difficulty feeling and expressing self-compassion likely did not receive much compassion from their caregivers when they were young, contributing to their core unmet need and leading them to instead enact self-criticism toward their younger selves. Sexuality change in the client as a result of this process occurs as a byproduct of resolving the core unmet need (the third and deepest layer of Figure 3), and is not the goal of the treatment itself. This is distinct from general forms of “conversion therapy,” which seek to modify the sexuality (the most superficial layer of Figure 3). Sexuality change is “conversion therapy’s” goal, not its byproduct. In this protocol, no

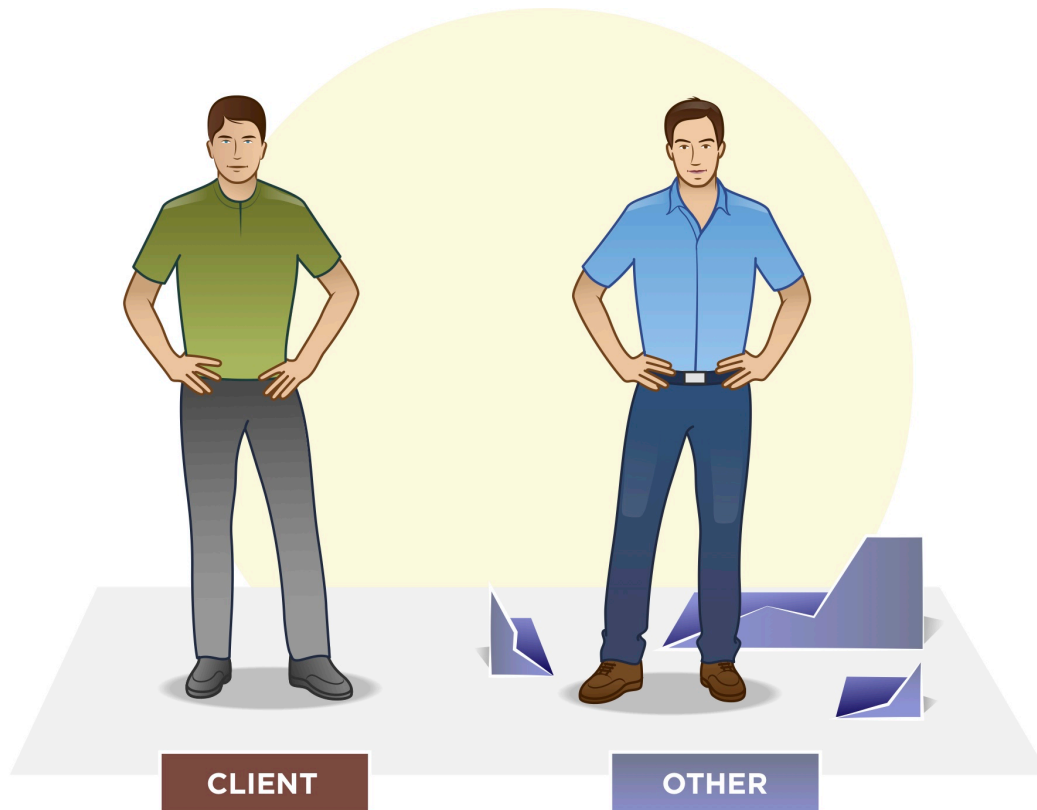


Fig. 6 Revisiting and reassessing the activating event.

effort whatsoever is made to modify the client’s sexual fantasy. The change only occurs on the deepest layer (layer 3– originating unmet need), which often causes layer 1 (sexual trance state) to simply disappear as a byproduct of the resolution of layer-3 dynamics. This has a wide variety of applications— clinicians have reported notable success in treating symptoms of Posttraumatic Stress Disorder, Other Specified Disruptive, Impulse-Control and Conduct Disorder, and a variety of paraphilia disorders with consistent use of the protocol.

In our experience of working with men who report same-sex attractions, at the end of phase 3, the client will virtually always spontaneously recall a moment of profound shame and attachment loss, typically at the hands of other hostile and rejecting males, an experience which, the client often reports,

resulted in the relinquishing of his masculine strivings.

Clients during phase 3 of this protocol who, for example, report sexual fantasies in which they feel “bonded” will likely spontaneously associate back to memories of being “alone” after inverting their gaze through their own eyes. Likewise, clients reporting sexual fantasies of feeling “powerful” in phase 3 will typically report experiences of feeling “powerless” and “stuck” when they invert their gaze. The emotional magnitude of the client’s addictive, compulsive behavior is generally in direct proportion to the magnitude of the client’s identified trauma memory (Figure 7) leading many clients and therapists to view the client’s addictive behavior as a deficit-driven phenomenon.

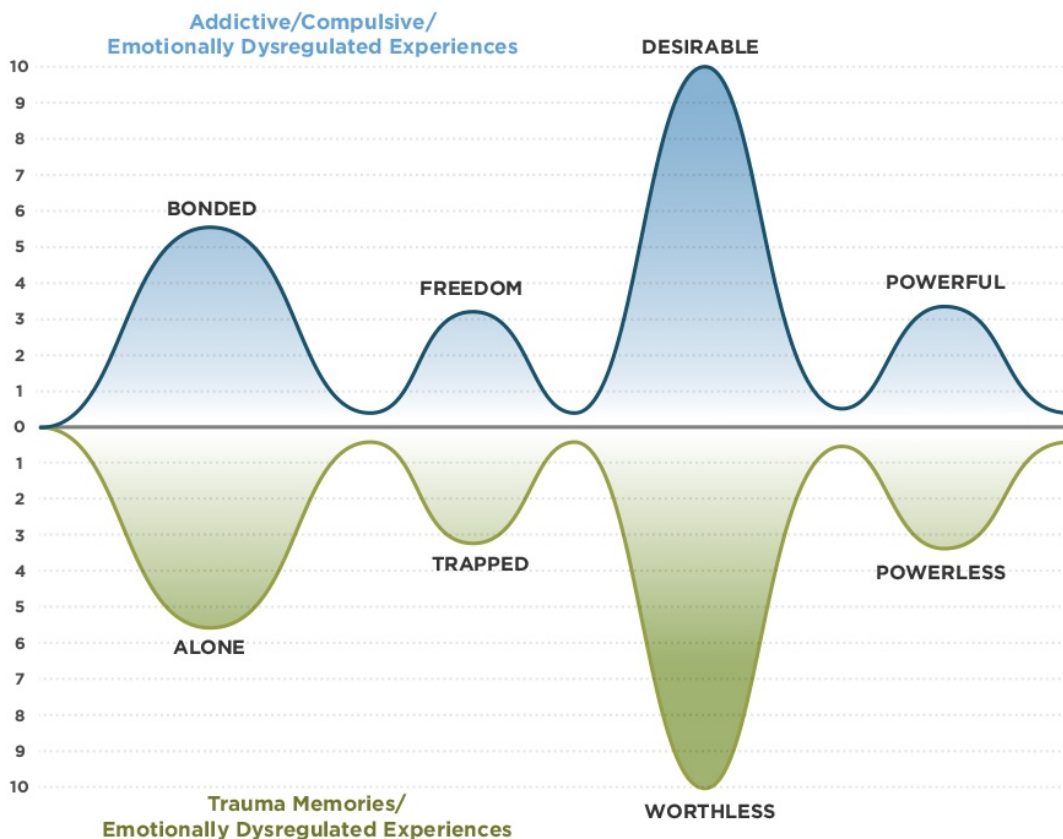


Fig. 7 Sample graph of affective dynamics from a client presenting with compulsive high-risk sexual behaviors.

This phenomenon is consistent across the behavioral spectrum—a gambler who has a rush of the feeling of “winning” will often spontaneously associate back to memories of “losing.” Binge eaters wishing to explore their bingeing behavior, who report feeling, for example, “complete” while bingeing, often spontaneously associate back to moments of emotional deprivation and “emptiness” (Figure 8).

When applied to men with same-sex attractions, this clinical observation has led several clinicians to view the client’s presenting material as a compensatory phenomenon—an attempt to restore affect dysregulation and sense of identity—and therefore remediate the effects of affectively dysregulated symptoms created by trauma and neglect experiences during the client’s developmental years. Other theorists,

however, offer a different explanation (Rosik & Popper, 2014).

With regard to male clients with same-sex attractions, gay affirmative theorists have traditionally posited that this phenomenon can be explained by the theory that the boy was rejected by his father and peers for being born gay, i.e., the client’s homosexuality was present from birth, and the boy was rejected by other males, either consciously or unconsciously as a result of this. In contrast, reparative therapy has postulated that traumatic rejection from the father and same-sex peers originally blocked the boy’s masculine strivings, and due to this traumatic shame and attachment loss, the client unconsciously developed reparative attempts to meet these unmet attachment needs in the form of same-sex attractions. Gay-affirmative theorists and reparative therapy theorists

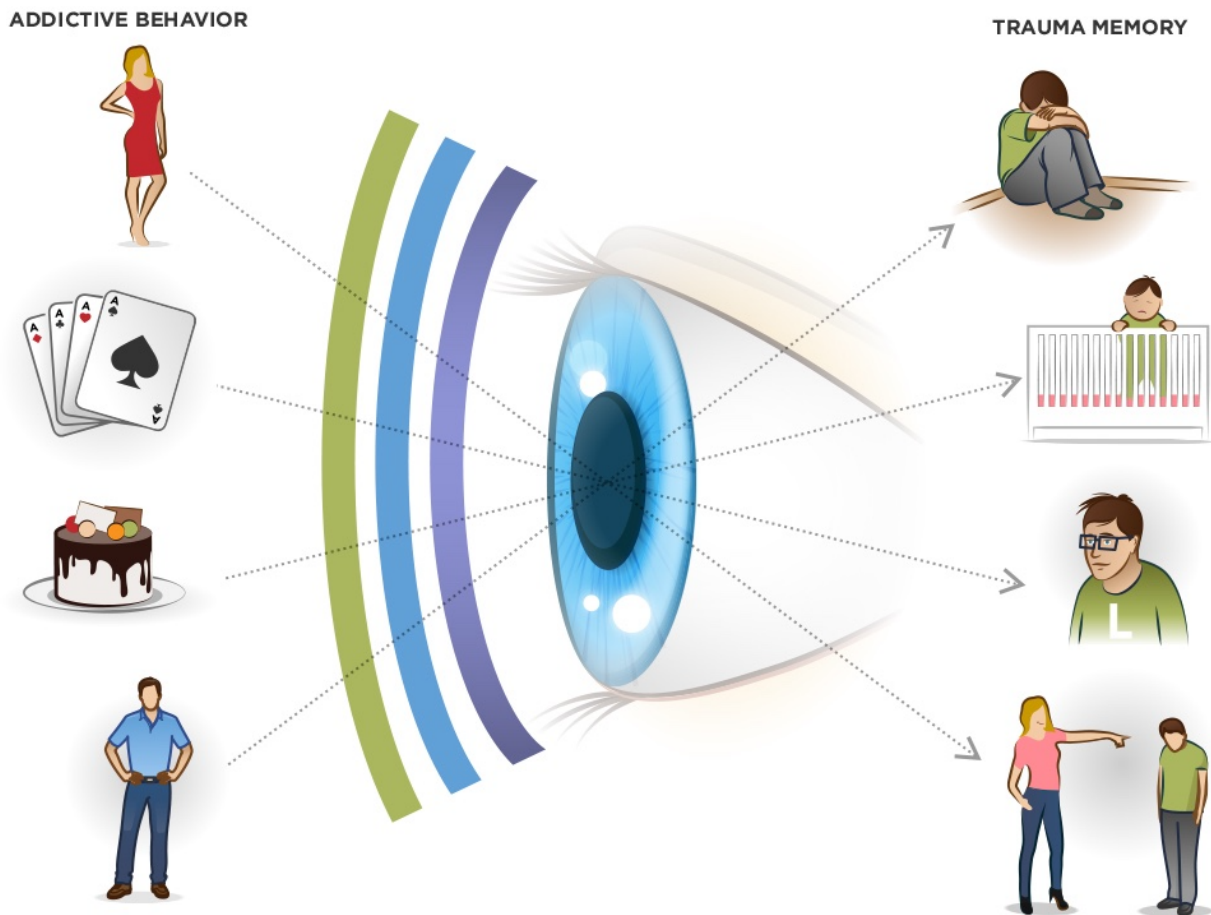


Fig. 8 Common associations across the behavioral spectrum

therefore posit reverse cause-and-effect explanations.

Fortunately, this protocol allows the client and therapist to side-step this cause-and-effect question. Regardless of the source of the client's homosexuality, he is now able to access and resolve his early trauma using this protocol. Resolving underlying trauma with self-compassion is beneficial to the client, making this exercise a worthy therapeutic intervention for clinicians who approach the topic of sexuality from many vantage points².

The protocol-driven approach reduces and at times, even eliminates the therapists' ideological influence in the treatment. This protocol, when properly applied, prevents the therapist from leading the client to a specific conceptualization of the causality of his behavior. The inversion of the trance-like feeling will cause the underlying trauma memories to "auto-select" and come to the surface of the client's awareness. It should be noted that, in my experience, clients with same-sex attractions, regardless of their various cultural and religious backgrounds, are very likely to spontaneously associate to painful memories of shame and attachment loss from other males. These clients who repeatedly use this protocol with Reintegrative Therapy® clinicians commonly notice that the compulsive, risky elements of their sexuality are the first to diminish as they become aware of their underlying unmet emotional needs and resolve them through self-compassion and/or EMDR.

To avoid so-called "implicit aversion" (non-verbal or otherwise unacknowledged elements of coercion that may be at play), clients are encouraged to inform their therapists right away if they notice themselves feeling any sense of judgment or coercion from their therapist. A competent therapist can collaboratively work with the

client to resolve this, and should do so before moving forward with this protocol. The client's experience of an open, accepting therapeutic alliance is the foundation for productive therapeutic work, as well as the understanding that clients have the right to set their own therapy goals, and to change those goals when they wish.

It is significant to note that clients consistently report the realization that their emotional states of compassion and shame are diametrically opposed to one another. As they grow in their capacity to give and receive compassion, they notice less shame in their every day lives.

Lastly, clients who feel overwhelmed by seeing negative affect in their own eyes during phase 3 may benefit by viewing their own eyes from a distance. Viewing the eyes from a distance allows for more gentle acknowledgment and resolution of the negative affect, without overwhelming and dysregulating the client during the process.

Cautions and Contraindications

Several cautions and possible contraindications for this protocol should be noted. Individuals who have obsessive compulsive disorder (OCD) may need additional preparation to benefit from this protocol, as the protocol requires sustained attention on an emotionally charged topic without lapsing into the ritualized mental activities brought on by OCD, something with which OCD sufferers have difficulty (Hershfield, J., & Corboy, T., 2013). Untreated OCD may need to be treated in phase 2 of this protocol, and may take several months or longer, depending on how quickly the OCD symptoms can be diminished to a degree that the individual is able to successfully use the protocol. Males with same-sex attractions may

be far more likely to have OCD (Sandfort, de Graaf, Bijl, & Schnabel, 2001). Though the implications of this topic are outside the discussion of this article, it is important to acknowledge that clients often benefit greatly from evidence-based OCD treatment, such as “The Mindfulness Workbook for OCD (Hershfield, J., & Corboy, T. 2013) during phase 2 of this treatment protocol. The mindful self-compassion exercises help prepare the client for the self-compassion work in phase 4.

Clients with severely impaired ability to recall childhood memories may require more time and understanding. Transgender clients may notice little to no sexuality shifts.

Finally, clients who are gay-identified should be informed that the repeated use of this protocol may lead to decreases in their same-sex attractions, and perhaps increases in their opposite-sex attractions as a byproduct. Many clients who are gay-identified, but wish to explore their attractions in a neutral way, and to resolve any traumas they may discover, do not see this potential shift in their sexuality as a negative side-effect. Though they often give consent for their sexuality to possibly shift on its own to whatever that result may be, it is only fair and responsible for the therapist to inform the client of this possibility before the repeated use of this protocol.

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² For more information, including further resources to assist therapists with this protocol, visit www.reintegrativetherapy.com