Multichannel Eye Movement Integration (MEMI)

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Creator of MEMI

Multichannel eye movement integration (MEMI) is a brief, solution-focused eye movement therapy designed to treat PTSD and other forms of anxiety. This new PTSD paradigm was developed by Mike Deninger, a trauma specialist, therapist, author and trainer, and a survivor of childhood sexual trauma (Deninger, 2021). MEMI is actually an expansion of the original *eye movement integration* (EMI) procedure created in 1989 by C. Andreas and S. Andreas (1993), both principals in the *neuro-linguistic programming* (NLP) field. Although procedurally similar to the first eye movement technique called *eye movement desensitization* (EMD) introduced by Shapiro (1989), EMI's theoretical underpinnings are manifestly different. EMI's protocol is grounded in NLP theory, principles and strategies, whereas Shapiro insisted EMD, and the *eye movement desensitization and reprocessing* (EMDR) protocol that followed, were not (S. Andreas, personal communication, March 6, 2016; Logie, 2014).

Because NLP's founding and its eye movement studies occurred more than a decade before EMD's invention, convincing evidence suggests that MEMI and EMDR emerged from the same source (Deninger 2021). Both techniques directed clients to focus on a visual representation of a distressing memory while simultaneously following the movement of a finger or an object like a pen with their eyes. According to Deninger, what made these first techniques so similar is their common ancestry. What made them different was the type of eye movements they used and the fact that EMI was a somatic and sensory-based approach, whereas EMD was more of a cognitive method.

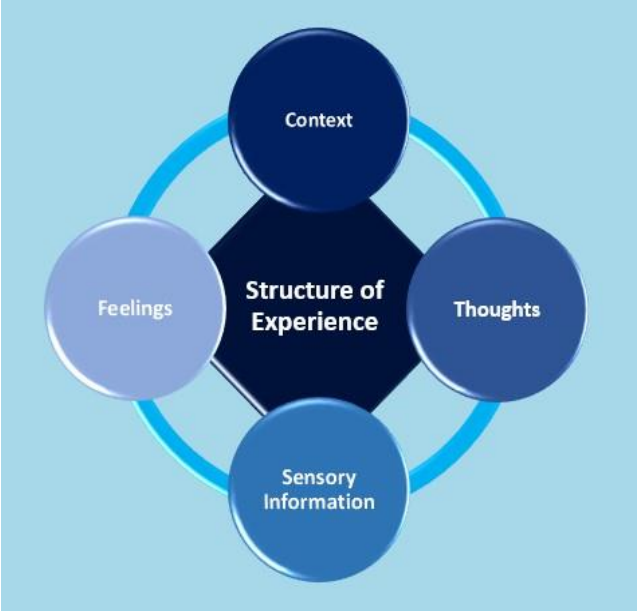
MEMI's simple protocol and procedures are informed by Deninger's use of the therapy with hundreds of survivors of all types: those who have experienced terrorist attacks, natural disasters, rape or sexual assault, work-related trauma, tragic deaths, war atrocities and life-threatening accidents. In *Multichannel Eye Movement Integration: The Brain Science Path to Easy and Effective PTSD Treatment,* Deninger (2021) argues that—as someone trained in EMDR, certified as an NLP trainer, and with 20 years of eye movement therapy experience—he was uniquely qualified to create a less complicated and more client-friendly approach than found in *eye movement desensitization and reprocessing* (EMDR) or cognitive and behavioral trauma therapies.

MEMI Theory

MEMI's straightforward theoretical model shown in Figure 1 is refashioned from the *structure of experience* theoretical model found in NLP (Deninger, 2021; Hoobyar and Dotz, 2013). In MEMI theory, the structure of every human experience is believed to be composed of its associated *Context* (who, what, when and where of an experience), *Thoughts* (cognitions)*, Sensory Information* (mainly images and sounds), and *Feelings* (visceral, emotional and tactile). Several NLP presuppositions supporting the model assert that all human experience is organized and systematic, that experience has a structure, that memories are stored and retrieved using sensory data, and that the structure of traumatic experiences can be reorganized in a beneficial manner with only four eye movement sets that traverse the entire visual field.

Figure 1

Structure of Experience Theoretical Model



MEMI and Context

The umbrella term *cognitive behavioral therapy* (CBT) describes a category of trauma methods cited frequently as the best bet for PTSD treatment. Two of the most recommended therapies in this category are *cognitive processing therapy* (CPT) (U.S. Department of Veterans Affairs, 2025a) and *prolonged exposure* (PE) (McSweeney, et al., 2020). The term exposure, as it relates to these interventions, refers to moments when clients are required to talk or think about a traumatic experience. In practice, an individual is asked to repeat the details of the trauma over-and-over, out loud, and in their own voice. In addition to being considered only marginally effective when compared to non-trauma methods (Bradley et al., 2005; Bisson et al., 2007; Schnurr et al., 2007; van der Kolk, 2015; Steenkamp, 2015), there is also widespread agreement that CBT methods are emotionally distressing for clients. In one CPT study, 82% of the subjects who reported a reason for dropping out said that the therapy was too distressing (Alpert, et al., 2020). Van der Kolk (2015) argues that one cannot heal from trauma, if overwhelmed by the intensity of repeated exposures. In addition, a recent systematic review and meta-analysis investigating this assertion found that dropout rates from recommended cognitive and behavioral therapies for PTSD are high (Lewis, et al., 2020). It appears that these therapies favor exposure over client security as a matter of course.

As it relates to vocalized exposures, MEMI clients are never required to divulge their trauma story. This means that the *Context* of the event—the who, what, when and where—might never be revealed to the therapist. Clients are given the choice, but the majority of them choose not to explain the details of their experience. For proponents of cognitive behavioral approaches, this may seem counterintuitive, but the proof is always in the results. Even the most disturbing memories can be reorganized in 1-3 sessions with MEMI, even though most clients choose not to explain what happened. The sensory-based nature of MEMI makes it unnecessary.

MEMI and Thoughts

With regard to what are called *Thoughts* in the MEMI model (cognitions in cognitive models), MEMI practitioners do not ascribe to the belief of Ellis (2008) that irrational cognitions must be identified and restructured in order to reduce trauma-related sensory and somatic intensity. On the contrary, extensive clinical experience with MEMI confirms that the opposite is true; irrational cognitions are automatically and reflexively transformed into neutral or positive statements following reductions in the intensity of trauma imagery, emotions and visceral feelings. There is no need for thought restructuring or tests and retests of cognitions. This finding raises questions about the efficiency of EMDR and cognitive and behavioral therapies which seek to identify maladaptive cognitions, transform them into more rational narratives and test and retest for cognitive improvements.

MEMI and Client Safety

The MEMI protocol emphasizes client comfort over exposure. To create an atmosphere in which clients believe they will be able to tolerate exposures, MEMI advocates the use of three specific safety mechanisms.

First, clients are never required to verbalize their trauma story, write it down, or in any way provide details of what happened, where it occurred, or when. As indicated, they can choose to describe the event if it is important to them, but narration of the trauma story is never a requirement. Instead, MEMI procedures call for the testing and retesting of the feelings and sensory reactions experienced during trauma recall and after eye movement interventions. Avoiding first-person retellings of the trauma story preserves a client's integrity during what are very brief MEMI exposures to a distressing memory.

Second, a procedure called *therapeutic dissociation* creates a visual, spatial, and temporal separation between the client and the image of the disturbing experience projected on a surface across the room. The client remains in the present next to the therapist and the offending trauma is assigned a location a distance away and in the past. This separator state between the client and the trauma's image is reinforced throughout a session with therapist comments and gestures such as: *Remember, that experience is way over there in the past* (therapist throws their voice in the image's direction and points toward its location).

Third, MEMI uses an empowering *reciprocal inhibition* (Wolpe, 1958) technique adopted from NLP called *resource anchoring*. Unlike relaxed breathing or cognitive stabilization techniques (e.g. the safe zone), with resource anchoring the client selects an experience from their past that is the opposite of the way they are reacting to a recalled trauma. If they describe their emotional reaction as *terrifying*, they are asked to select an opposite word. If they respond that the opposite of terrifying is *empowering*, they are asked to think of a past experience when they felt completely empowered. The therapist then helps the client rekindle the uplifting feelings and sensations associated with the empowering experience with quasi-hypnotic vocalizations. When the practitioner observes that the client's physical and emotional responses to the empowering experience have peaked, they intone the word empowering three times with emphasis. This *anchors* those sensory responses in memory for use in counteracting exposures during the eye movements. And as with therapeutic dissociation, the therapist reminds the client throughout the session that they are feeling just as empowered in the present as they were during that uplifting experience from the past.

These dynamic safety mechanisms make MEMI a more user-friendly approach than other trauma-focused therapies. At the same time, the therapy's uncomplicated theory and protocol make MEMI easier for mental health professionals to learn and use.

MEMI's 10-step Protocol

MEMI's straightforward theoretical model is bolstered by the therapy's concise, 10-step protocol. During the first six steps, a working alliance is achieved, a commitment to change the reactions to the

traumatic memory is sought, a resource anchor is established, therapeutic dissociation is introduced, a pretest of thoughts, sensations, and feelings is conducted and the results are recorded on a worksheet. In steps seven to nine, the four eye movement sets are performed, retests of images, sounds, emotions and physical reactions are conducted using formative assessments, and the results are recorded on a worksheet. Finally, in step 10, a *future rehearsal* is conducted to test the effectiveness and durability of MEMI results in a future time and place. Because only four standard eye movement sets are used in a typical MEMI session, results are achieved much more rapidly when compared to traditional trauma methods.

MEMI and EMDR

MEMI and *eye movement desensitization and reprocessing (*EMDR) share several procedural elements. Both therapies use a multimodal approach, which seeks to improve the cognitions, emotions, physical feelings, and imagery related to an experienced trauma (Deninger, 2021; Shapiro, 1995). They each use smooth pursuit eye movements, a divided consciousness technique, a test-retest model, and *subjective units of distress* (SUD) scale. Deninger (2021) references interview research he conducted to support his contention that EMDR adopted several models and strategies that actually originated in NLP. Rosen (2023) cites carefully researched historical events, when arguing that the evidence is strong that EMDR has deep roots in NLP.

The encouraging news, as far as both interventions are concerned, is that the process by which fear memories are formed in the amygdala has reportedly been discovered (Fu et al., 2022). Furthermore, the remarkable role that eye movements play in reducing fear memory activations in the amygdala has been confirmed (de Voogd et al., 2018; Mace et al., 2018). As definitive as these results are, there is one caveat related to the research designs in these two studies. Only bilateral eye movements were used in both experiments, presumably because those are the predominant eye movements used in EMDR. However, Shapiro's reasoning for why she decided to use bilateral eye movements in her first experiment—and then made them standard in the EMDR protocol—lacks empirical support. In her first edition of *EMDR: Basic Principles, Protocols and Procedures,* Shapiro (1995) explains in vague and imprecise terms the tests she conducted to determine which eye movements she decided to use in her procedure and why:

> *. . . I tried different kinds of eye movements (faster, slower, in different directions) and I asked people to concentrate on a variety of different things (such as different aspects of the memory or the way it made them feel. As we proceeded, I began to learn which strategies were most likely to get positive and complete results. (p. 3)*

This description's lack of specificity obfuscates the actual process Shapiro used to determine which eye movements would be most effective in reducing cognitive, sensory and somatic reactions to traumatic experiences. Prior to her experiment, Shapiro had learned from her associations with NLP developers that eye movements are organized and systematic, and that specific locations in one's visual field relate to the types of sensory processing occurring simultaneously in the brain (Deninger 2021). Years before her experimental study, Shapiro had worked in the training office of John Grinder, one of NLP's founders. She also taught NLP seminars and wrote about NLP's eye movement discoveries (Rosen, 2023). Not to reference her experience or those NLP findings seems odd—perhaps intentional. This is not meant to diminish EMDR's efficacious track record confirmed by numerous studies. Rather, it raises a research question about the efficiency and effectiveness of bilateral stimulation, when compared to the use of a variety of eye movements to all locations in one's visual field.

There are also distinct differences between MEMI and EMDR.

Whereas EMDR generally uses bilateral, horizontal saccades at eye level in its model, MEMI practitioners guide a client's eyes to all locations in the visual field, a difference that Deninger (2021) proposes is one reason why client PTSD symptoms are reduced more rapidly with MEMI than EMDR (1-3 sessions

versus to 6-12 sessions respectively). According to Guy-Evans (2025), 6-12 sessions over several weeks are required for EMDR treatment. According to the EMDR International Association website, it could take one to several 60-90-minute sessions to process a single traumatic event (EMDRIA, 2025). The U.S. Department of Defense's PTSD Center (2025b) reports 1-3 months of weekly 50-90-minute sessions are required for EMDR treatment, although people might begin noticing improvements after a few sessions. EMDR is considered an empirically validated treatment for PTSD (Landin-Romero et al., 2019), even though the mechanisms by which it works are still not understood (U.S. Department of Veterans Affairs, 2025b; Guy-Evans, 2025).

Empirical studies of MEMI's efficacy are now getting underway. The therapy's first outcome study is investigating MEMI's effectiveness when used with First Responders in peer-to-peer support networks. The study is a cooperative effort between One Tribe, Stephen F. Austin University, HC Solutions, Training & Consulting and Trauma Counseling & Training of Tucson (B. Simmons, personal communication, March 1, 2025). A second research proposal has been designed to study the use of MEMI with deaf and hard of hearing individuals by a panel of researchers from Gallaudet University and Deaf Wellness Center of the University of Rochester Medical Center.

Another aspect to consider when comparing MEMI and EMDR is whether the cognitive and linguistic demands of each support their use with underserved populations. An analysis of MEMI and EMDR procedures reveals that EMDR involves significantly more complex language and reasoning demands than MEMI. In EMDR, a client's life history is taken (to assist in identifying overarching themes and patterns), free-associative questions are asked to detect earlier pathologies linked to the trauma, and testing and retesting of cognitions are done using EMDR's *validity of cognitions* (VOC) Scale (Shapiro, 2018). MEMI has fewer language and abstract reasoning demands than EMDR. The therapy does not require elicitation of a client's life history, details of the trauma, irrational cognitions, or the processing of other related pathologies through free association. Instead, MEMI targets the somatic and sensory reactions to a trauma, with infrequent tests of cognitions. This makes MEMI a *bottom-up* approach, whereas EMDR can be viewed as more cognitive than sensory. Given these differences, MEMI appears to be a better option for individuals with limited language skills or cognitive deficits when compared to EMDR.

MEMI as a Bottom-up Approach

The last two elements in MEMI's theoretical model are Sensory Information (images and sounds) and Feelings (visceral, emotional and tactile). To demonstrate MEMI's bottom-up nature, Figure 2 depicts how pretesting and retesting of visual imagery after each eye movement set might be recorded. In the pretest, the client reports the image of the experience is a movie, it is near, and it is clear (indicated by the underlines). This baseline information is expected to change in a beneficial manner after eye movement sets. A five-point i*ntensity scale* (I-Scale) is used to obtain an intensity score for the image, with 0=no intensity and 4=the highest intensity. The "X" in the pretest indicates the image is given a score of 4—the highest intensity. As indicated previously, only four eye movement sets are usually performed in a MEMI session, compared to the 10-20 that might typically be required in EMDR. In Figure 2, after eye movement set 1, there is no change, so that line of the worksheet is left blank. But after set 2, the client responds that the image is less clear, causing its intensity to reduce to a 2 (moderate). After set 3, the client reports the image is not a movie anymore and gives an intensity score of 1 (mild).

Figure 2

MEMI Worksheet: Visual Imagery Example

SENSORY INFORMATION										
3. Visual						**4**	**3**	**2**	**1**	**0**
Pretest *(circle one from each pair, if applicable)*						High ← I-Score →				Low
Movie/Still photo	Color/Black & white	Near/Fara way	Fuzzy/Clear	Bright/Dark		X				
Set 1:										
Set 2:	Less clear							X		
Set 3:	Not a movie anymore								X	
Set 4:										

Figure 3 depicts how visceral feelings might be scored during a MEMI treatment session. In the pretest, the client reports head throbbing at the temples and rates the intensity of the pain at 4 (the highest). Again, after set 1, there is no change and the line is left blank. But after set 2, the client reports that their head is throbbing less and rates the intensity at 2 (moderate). And after set 3, the client reports the head throbbing is gone and reports a score of zero.

Figure 3

MEMI Worksheet: Visceral Feelings Example

FEELINGS						
5. Visceral *(stiff neck, nausea, etc.)*			High ← I-Score →			Low
Pretest	Head throbbing at temples		X			
Set 1:						
Set 2:	Head throbbing less				X	
Set 3:	Head throbbing is gone					X
Set 4:						

MEMI's SUD Scale

MEMI also employs a SUD scale to determine the distress level of an entire experience, but it is applied differently than in EMDR. In MEMI, the SUD level during the pretest is arbitrarily set at 100%, meaning that is the distress level one usually experiences each time they recall their traumatic memory. Clients are informed that, if their I-Scores (visual, visceral and emotional) to the experience improve after eye movement sets, the SUD score might also go down to 90, 80, or 70%. EMDR uses a 10-point SUD scale with zero representing no distress and 10 representing the most severe distress. The goal in EMDR is to reduce the SUD score to zero. In contrast, the SUD goal at the end of MEMI treatment is 50%. With a SUD score of 50% or less, clients routinely report that the traumatic memory will be manageable going forward. Perceived manageability is also one criterion for MEMI treatment success.

Figure 4 illustrates how SUD scores might be reduced related to the same problem depicted in Figures 2 and 3. After eye movement set 1, the SUD decreases to 85%, even though the I-scores had not yet decreased. After set 2, the score decreases to 60%, and after set 3, the score goes down to 30%. Because the reported SUD was less than 50% after set 3, treatment could then be brought to a close.

Figure 4

MEMI Worksheet: SUD Scores Example

SUD SCORES					
Pretest = 100%	Set 1: 85 %	Set 2: 60 %	Set 3: 30 %	Set 4: %	Set 5: %

MEMI and the PTSD Checklist for DSM-5

Summative evaluations of PTSD symptom improvements are assessed using the PTSD Checklist for DSM-5 (PCL-5) developed by the U.S. Department of Defense's PTSD Center (Weathers et al., 2013; Wortmann et al., 2016). The checklist tests for the presence of diagnostic symptoms subsumed under the four PTSD symptom clusters contained in the fifth edition of the *Diagnostic and Statistical Manual of Psychiatric Disorders* (DSM-5): Intrusions, Avoidance, Alterations in Cognitions and Mood and Arousal and Reactivity. The checklist is administered before treatment commences and again at least one month after its conclusion. Outcomes from initial evaluations of the MEMI protocol using the PCL-5 have shown very promising results.

MEMI Courses and Certifications

Currently, MEMI courses and certifications are offered to four groups of professionals through Trauma Counseling & Training of Tucson and its affiliated network of licensed trainers. Each course requires at least 12 hours of in-person or virtual instruction. To obtain MEMI certification applicants must also pass a test of instructional content and complete 10 consultation hours with a licensed MEMI trainer. The clinical course for licensed mental health professionals has two versions: one for Deaf therapists (presented in American Sign Language) and a second for all others presented in English. On-demand webinars for each of these courses can be taken online at the following link: https://multichanneleyemovementintegration.com/webinars/

The third course is a non-clinical version designed for certified NLP practitioners, hypnotists and coaches. It can be taught in-person or taken online at the previous link. The fourth and newest course is a five-day, non-clinical training designed for the First Responder population (e.g. law enforcement, emergency management service personnel; active-duty military and vets; and non-profit workers and volunteers who provide trauma care directly, or as a part of peer-to-peer support networks). This course is taught in-person by Brian Simmons, the MEMI licensed trainer in Texas. A description of this program can be viewed at: https://acrobat.adobe.com/id/urn:aaid:sc:va6c2:066bbde4-5f37-44d1-8804-56d8010befcb

To inquire further about MEMI, its courses and certifications, visit https://multichanneleyemovementintegration.com or email info@multichanneleyemovementintegration.com.

Clientele Who Would Benefit Most from MEMI

Although MEMI was designed as a PTSD and Acute Stress Disorder treatment, its effectiveness is not limited to these disorders. MEMI can also be used to treat most other mental health conditions, as well as less severe—but nevertheless distressing—life events that individuals experience. A longstanding regret about not completing college, a personal affront from a friend, a lost love, or a confrontation at the office are examples. Furthermore, because of its multifaceted nature and content-free design, MEMI can also be used in tandem with other theoretical approaches. There is no problem so big or so small that it cannot be addressed with MEMI. This simple and safe, yet remarkably fast and reliable protocol, is a tool that practitioners will want to add to their treatment regimens.

Cautions or Limitations

The use of a divided consciousness technique in MEMI—when a client is asked to visualize a trauma while simultaneously following the movement of an object with their eyes—requires that the client have the intellectual capacity to perform these two tasks. Clients with cognitive or language deficits may have difficulty with this dual-attention procedure. Young children who have not yet made the transition from concrete to abstract thinking will have similar difficulties. Clinical experience has shown that by 8-10 years of age, most children are able to perform the dual attention task from MEMI procedures. When in doubt, screening for the ability to think in the abstract may be necessary.

Clients with hallucinations, delusions or sensory distortions will have difficulty with the dual attention task for different reasons. For example, a schizophrenic client, distressed by a crow who they believe is the devil berating them from outside a window, may be unable to benefit from MEMI, because they perceive the auditory and visual hallucinations as irrefutable and unalterable. Their perceptions are not a result of stress response limbic activations, but caused by a separate anomaly. However, there may be certain situations in which sensory distortions can be overcome.

An individual with *aphantasia*—defined as an inability to visualize experiences—could benefit from MEMI treatment by targeting a different sensory element in the memory's structure. Instead of a focus on the visual image, the target during the eye movements could become the auditory, visceral or emotional reaction to the experience. In MEMI the structure of an experience is believed to be organized and systematic, meaning that a change in one sensory modality will produce changes in other modalities and/or to an experience's entire structure. This coactive relationship exemplifies the *law of requisite variety* (Ashby, 2015), a core concept embraced in NLP. In this theory, when a system's success is hampered by barriers in its environment (one might substitute *ecosystem* here), the system's ability to overcome those barriers must be as varied and nuanced as the universe of environmental barriers. For example, if one of the system's elements is inoperable (e.g. as a result of aphantasia), an alternative path to success would be to focus on a different sensory element. The more flexibility a system exercises in overcoming all the environmental deterrents to success, the more efficient and effective it will be. In this case, instead of a limitation, requisite variety allows MEMI to outperform other approaches due to its synergistic ability to solve problems impeding change.

One other caution regarding the use of MEMI, although not exclusionary, has to do with co-occurring client conditions. No significant research has yet been done on the effects of smooth pursuit eye movements on subjects with epilepsy, although some have raised concerns that eye movements might trigger seizures. To err on the side of caution, providers should check with a specialist prior to proceeding. Other individuals have problems smoothly tracking a moving object, as when the eyes lurch and then stall from one location to another. Addressing this by verbally instructing clients to move their eyes to different locations, instead of having them track an object's movement is one way to overcome this complication. And lastly, an erroneous assumption is sometimes made about the ability of low-vision clients to benefit from eye movement therapies. Of course, the degree of impaired vision will be the strongest factor in determining whether an eye movement approach will benefit someone who is blind. But if an individual has some sight in parts of the visual field, a practitioner might use lighting directed on the movements to creatively enhance an individual's ability to track the motion.

Is there an ideal MEMI Professional?

To be certain, any practitioner who works with trauma clients—or who aspires to—should consider becoming trained and certified in this new therapy. MEMI's ability to rapidly replace the debilitating reactions to traumatic experiences with manageable reactions—when compared to extant trauma therapies—is its strongest feature. Given this reliable result, one could argue that there is not one ideal professional for whom MEMI is best suited; there are many. Whether you are a seasoned therapist or a developing counselor, MEMI's uncomplicated theory, simple procedures and rapid outcomes will be attractive qualities. As an

added inducement, the cost of MEMI's clinical training and certification is effectively half of what one would expect to pay for similar eye movement therapy certifications.

When Deninger transformed EMI into MEMI, the goal was to develop a comprehensive clinical therapy from the earlier NLP technique developed by Steve and Connirae Andreas. In addition to taking hold as the newest clinical eye movement therapy, MEMI's healing power is now being extended to underserved populations. One advancement has been the development of a MEMI course for American Sign Language (ASL) proficient therapists who serve deaf and hard of hearing clients. In 2022, the first live training was conducted at Arizona Trauma Institute and the videotaped presentation was converted into a 12-hour webinar now available for purchase at Webinars - Multichannel Eye Movement Integration (MEMI). To date, approximately 30 ASL therapists have completed all requirements for MEMI certification. That number is expected to grow to about 60 after additional live streamed ASL courses are conducted in summer, 2025 and spring, 2026. A community of MEMI trained ASL providers has been established and is growing.

This is also why Trauma Counseling & Training of Tucson introduced its two non-clinical eye movement models; one for use with First Responders and the other to train NLP practitioners, hypnotherapists and coaches in the use of MEMI. These innovations will help bring the healing power of eye movements to trauma survivors across the spectrum.

Summary

The descriptors *trauma-informed care* and *trauma-focused treatment* are now endemic in the mental health treatment vernacular. Recent research confirms that the helping professions are now addressing the stunning implications of the Adverse Childhood Experiences (ACE) Study (Filetti et al., 1998). The evidence is strong that negative childhood experiences are reliable predictors of major medical and mental illnesses in life's later stages. Combined with burgeoning evidence about the effects of threatening experiences on the human limbic system, efforts to more closely align neurological findings with treatment orthodoxy are increasing. Where that is not happening, it should be.

Unfortunately, bringing evidence-supported eye movement approaches to all those in need remains an elusive goal. Heretofore, eye movement certifications have been restricted to licensed mental health clinicians. This has limited access to care. Many individuals with PTSD are unable to find a clinician certified in an eye movement method, or they simply cannot afford the cost of treatment sessions. To be more precise, trauma survivors from poor, uninsured, veteran and immigrant groups have limited access to general mental health treatment, and much less access to trauma care using eye movements. The National Institute of Mental Health (2025) estimates that approximately 3.8% of the adult U.S. population—9 million people—are living with PTSD at any given time, but only 50% of that number receive treatment. Obviously, there are not enough trained therapists to meet the need, and far fewer trained in eye movement therapies.

MEMI's clinical certification prepares therapists to resolve PTSD symptoms more expeditiously than existing eye movement therapies. Furthermore, MEMI's non-clinical certifications offer memory reprocessing alternatives that do not require formal (accredited) mental health training or professional licensure to be administered. Because the MEMI protocol is an expansion of NLP's Eye Movement Integration technique developed in 1989, MEMI's non-clinical certifications represent a return to the techniques origins in NLP. All of MEMI's training and certification programs are structured so that participants are equipped with the knowledge and skills they need to use the protocol safely and effectively. Licensed mental health professionals, coaches, NLP practitioners, hypnotheraists, crisis intervention workers and peer support personnel can be trained to use MEMI to help others reprocess difficult memories. In this way, eye movement reprocessing is now becoming more accessible to the generable public. And for this reason, MEMI has been designated by its developer as *The Peoples' Eye Movement Method.*

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Mike Deninger, PhD, MA, LPC

Bio

Mike Deninger is a licensed professional counselor, author, master trainer and internationally recognized expert in the use of eye movement integration techniques. After earning a graduate degree in special education and a PhD with distinction in special education administration, he rose to a national leadership position in the education of deaf children at Gallaudet University. That all changed, however, when he was diagnosed with PTSD as a result of traumatic experiences from his youth. Following his recovery, he embarked on a new career in mental health, earned an advanced degree in Mental Health Counseling and opened a private practice where he specialized in the treatment of all forms of trauma.

Mike was subsequently awarded trainer certifications in Ericksonian Hypnotherapy, Neuro-Linguistic Programming and Eye Movement Integration from the American Hypnosis Training Academy. He also received intensive training in EMDR. He has been using eye movement therapies with PTSD clients of all types and stripes for 25 years. They have included active-duty military and vets; physical and sexual assault victims; police, firefighters, and EMS personnel; 9/11 first responders; witnesses to violence; and survivors of terrorism, accidents and natural disasters.

Mike's innovative approaches to treating trauma and anxiety led to the 2021 publication of *Multichannel Eye Movement Integration: The Brain Science Path to Easy and Effective PTSD Treatment.* A second edition of this book is planned for publication in 2025. A feature article describing MEMI authored by Mike and Joachim Lee, Trauma Counseling & Training's Principal Trainer, appeared in *The Science of Psychotherapy* journal. His work has also been featured on the podcast *Shrink Rap Radio* and the video podcast *Science of Psychotherapy*.

Mike's attention is now focused on training, mentoring and certifying therapists, coaches, NLP practitioners, hypnotherapists and First Responders in the MEMI protocol and other techniques he has developed. Through live trainings and on-demand webinars MEMI courses are now offered in clinical and

non-clinical applications of the method. Through his business *Trauma Counseling & Training of Tucson* and its certifying body *MEMI International*, the healing power of MEMI is spreading rapidly to all corners of the globe. Mike has given presentations and keynote addresses at hundreds of national and international conferences—most recently at MEMI's First International Conference in Singapore—and trained thousands of mental health and allied professionals in bottom-up approaches to treating PTSD and lesser forms of trauma.

Mike can be contacted at info@multichanneleyemovementintegration.com. For information about MEMI courses and certifications visit: https://multichanneleyemovementintegration.com/training/.