SHAPIRO SERIES #7

SLIDE #7

D - DISTORTIONS ARE TO BE AVOIDED

* PATHOLOGY IS BASED ON INFORMATION, AS IT IS CURENTLY STORED
* INFORMATION IS ACCESSED, AS IT IS CURRENTLY STORED
* IT IS TRACKED AS CURRENTLY STORED
* IT IS PROCESSED AS CURENTLY STORED
* IF MANIPULATED, IT IS RE-ACCESSED AND REPROCESSED AS CURRENTLY STRODED
* IT IS REEVALUATED, AS IT IS CURRENTLY STORED

Distortions are to be avoided. A= Adaptive assimilation; B= Brain is part of the body; C= connections and channels; D= Distortions are to be avoided. What does that mean? The pathology is based on the information, as it's currently stored. In the brain. The symptoms are coming up; the reactions are coming up from this information because of the way it's currently stored. The information is accessed, as it's currently stored. When we bring together the image, the cognition and identify the emotion and the physical sensation, it is as if we are directing three laser beams at the dysfunctional material. We are accessing it in a controlled manner, as it is currently stored. But we need to make sure we're tracking it, as it's currently stored. When we say, "what do you get now?" Material is allowed to come up, as it is currently stored. And the material is supposed to be processed, as it's currently stored. Which means if you ask the client to generate insights, or talk excessively about what they notice now, we are taking them out of the processing.

In the early days of training, we had a lot of trouble with clinicians interrupting processing. Many clinicians were trained in cognitive behavioral therapy and breathing skills, and so in the middle of processing, they would start using their CBT or breathing techniques and the processing would stop. The clinician had just introduced another state. They're not letting the client stay in the processing, as it was currently stored. The way it's currently stored needs to be available so that the client is able to go down all the associated channels that need to be processed. When you have a client stabilized on benzodiazapines, we know that after they've processed the information and as a result, their medication have been reduced, you need to go back and retarget the issue. You may find that what was a "0" is now at a "5" because the meds suppressed the affect. Not all the associated channels were completely processed due to the suppressing effects of the medication. That's why you have to go back and process the issue again.

Equally important to remember, however, is by using guided visualization, affirmations, resources, containers, or whatever techniques you're using to suppress affect is also doing the same thing. So if you felt it necessary

to use a guided visualization, affect management or a resource, keep in mind you need to go back and process the issue in an undistorted manner. Eventually you have to go back and use the standard protocol or you haven't used EMDR. You've "mushed" something together, not allowing those channels to be processed. So if we've manipulated processing, we have disrupted the client's adaptive information processing system, we run the risk of taking them out of the channel and disrupting processing. Therefore, every time we use a intervention or cognitive interweave, we have manipulated the processing - we have introduced what we believe is the next bit of information and as a result, we may have taken them off target a little bit, or caused them to jump over a portion of an unprocessed channel.

Anytime we tell them to do something that hasn't come up spontaneously we distorted it a little bit. Well that means you have to go back and do it in an undiluted manner. And we need to constantly re-evaluate our work. It's not just during that session. Remember what I said about long-term trait change, not just temporary state change. So perhaps at the end of the treatment session it appears as though full consolidation and integration have occurred. Do we know for sure? No. Not until we have re-evaluated the client's progress, and not until we have treated all past issues, present triggers, and installed the desired future template. Next week and certainly before termination we need to recheck major memories, present triggers and the client's ability to integrate the changes that occurred during processing in their future actions.

And remember - anything you have distorted, through the use of guided imagery, hypnosis, round table, inner child, resources, cognitive interweaves, etc., has got to be reevaluated because you have distorted the processing. While all those interventions are valuable for some clients, remember they are distortions to the natural flow of the adaptive information processing system. If you have used an intervention for whatever reason you felt it necessary, you have to go back and make sure you cleaned it all out. Because those interventions are like the benzo's, they mask processing and are temporary. Hypnotic suggestions pass, affirmations, unless they're constantly reinforced, passes. Resources, again if not constantly reinforced, pass. What you're looking for is full and complete processing. So it's re-evaluated, as it's currently stored. And at the end of the session, if you've manipulated it, that's the way, it's coming up. That's why you have to make sure and go back the next time. And the time after that. Make sure that it's kept in good shape. The bottom line is preparation is not processing.

All these great things that I see being suggested in the field: the ability to make EMDR treatment more robust, such as the history taking strategies, the extended preparation strategies - fabulous. Just fabulous. Ways of doing a complete re-evaluation-fabulous. The more wisdom we can bring in

from all different orientations, the better because we all want the same thing. We want healthy happy clients that can bond and love and connect. That's what we want. But seeing them with a smile on their face at the end of the session doesn't mean we have accomplished that goal.

We have had an upsurge in clients calling The Institute over the past year saying, "I'm really confused. I've been doing EMDR for weeks or months and I love my clinician. We have great rapport and I feel great at the end of every session but when I go home, my issues are still there. I'm just not getting any better. And when I read this book about EMDR, it doesn't sound like what they're doing with me." When we at the Institute say, "Well, did you speak to the therapist?" they say "well, yeah, but they say...." So it is important that we know what EMDR is, that we inform our clients not only when we are going to treat them with EMDR, but also, and perhaps more importantly, when we are going to treat them with something that is not the Standard EMDR Approach. It is our professional and ethical obligation to inform our clients that we are going to treat them with an approach that has been backed by research, and when we are going to use an experimental variation, which may or may not even be considered EMDR.

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