SHAPIRO SERIES #8

SLIDE #8
E-EVALUATE EVERY EXPERIENTIAL CONTRIBUTOR
- EVERY EXPERIENTIAL CONTRIBUTOR SHOULD BE EVALUATED, ACCESSED AND PROCESSED
- EXPERIENTIAL CONTRIBUTORS ARE POSITIVE AND NEGATIVE
- EVALUATE DIFFERENCE BETWEEN SYMPTOMS
- EVALUATE INDIVIDUALLY AND SYSTEMICALLY

While Preparation is important, everybody doesn't need a lot of preparation. AND remember, preparation isn't the processing. As part of your clinical assessment of the client your task is to identify how much preparation is needed? Because our client needs to have to a certain stance (stable, intact) in order to handle reprocessing the experiential contributors (target memories)

"E," EVALUATE EVERY EXPERIENTIAL CONTRIBUTOR: The experiential contributors to health as well as dysfunction. So, yeah, there's genetics, no question. Yes, there's "I didn't sleep very much last PM and I'm tired and that's effecting me." Absolutely. But we're looking at experiential contributors that are stored in the brain that need to be evaluated, accessed and processed. Does every single one need to be processed? No, because we have the generalization effect. But they need to be evaluated. Experiential contributors, positive and negative. What good things have happened to them, what positive people have been in their lives that are going to assist in "what do I use to help prepare them?" What might I use for a cognitive interweave? What relationship do they have with their children? Will I need to bring that in with, "what if your child...." during a cognitive interweave? Positive ones that let us see what they have and what they are going to need. You have to evaluate the difference between symptom reduction and comprehensive treatment. Let's say someone comes in with a driving phobia. If I just concentrate on the driving phobia and send her back to a life of quiet desperation I wouldn't personally consider that good work unless that's all she's willing to do. But as a clinician, if I'm taking a history and seeing the larger clinical picture, at least let me make the person aware of the possibilities and the potentials to see if there are other issues they would be willing to address that would improve their quality of life. In part, because the symptoms of the phobia or PTSD may be masking other dysfunctional material and symptoms. It's like taking the quilt off the mattress. Once the quilt is removed, you may see of lumps and bumps on the mattress that you need to deal with. So if I take a good clinical history, I'm able to identify what might need to be processed to help get this person to an actualized state. Not just actualization for

some of their issues; actualization for all of their issue. EMDR is a positive, self-actualizing approach, not just a trauma desensitization model where we just address the obvious issue and then let them continue to limp along with other inhibiting issues. We want them to be dancing with emotional health, don't we?!

Evaluate individually how they are with you (the clinician) and systemically how are they when they are with their family, social settings, and larger settings. To do this, we need the client/clinician feedback loop. When we say in research "you should be able to process a single-event trauma in 3 sessions" that doesn't mean that's all the therapy you should do. It's giving you a rule of thumb in terms of processing but what you are hopefully looking for is how do I bring this client to a level that perhaps they never even knew was possible. And is it OK with you if they go even further than you think they can or further than you may am able. In the clinical tapestry, we're looking for positive and negative experiences and we want to use every possible orientation (clinical tool) in order to bring in these possibilities and targets.

If you're talking to a person from a psychodynamic perspective, you're going to be looking at family of origin issues; you're going to have a sense of defenses. What is a defense? It's a habitual way that the client learned to respond in order to survive during the earlier/younger times in their life. Where does that come from? Earlier memories. What are the earlier memories that need to be processed? All of these are to identify where we have to look in terms of foundation memories.

What present situations need to be addressed? Transference - what does that mean? Transference is their habitual way of responding to people, and therefore, it is something they may do with you. So from those behaviors you can identify the habitual characteristics and beliefs they have about themselves, link it back to the earlier memories, and identify them as targets for reprocessing. All of it is feedback for the client, whether they choose to address these targets with EMDR or not.

BEHAVIOR THERAPY - we do functional behavioral analysis. Last time you were, upset, what happened? (That's the present trigger) What were you seeing? Visualizing? (There's the image) What were you thinking about yourself? (The negative cognition) How did you feel? (There's the emotion) Where did you feel it in your body (sensation) what did you do after that? "I went and drank." (That's the habitual way -dysfunctional coping strategy- the client needed to use in order to deal with the situation). You can see the connection and you get to see what types of experiences you're going to need to process for the past, the present, and the future template.

COGNITIVE THERAPY - gives you beliefs to use. "I'm helpless." "I'm

hopeless." "I'm unlovable." "I can't succeed." Where did it come from? What earlier experiences set these into motion?

HYPNOSIS- use a timeline. Start from "0." What was going on in family interactions then? Write it down. Year of birth. How were they physically? What comes up for them? Not that they can remember what happened when they were 1 years old. But they remember what were they told about being 1 year old. Which brings up the issue of "do you have to do pre-verbal trauma?" Well, conceptually everything's linked here. The experience might be in a somatic level but once you learned language, it's linked in. And these experiences are linked in with the other memories. So I have plenty of targets I can address to process things that are going to go down into earlier somatic channels. I don't have to go looking for them. They're going to be linked to the targeted node and most likely come up during reprocessing. If they are not connected, let's worry about them at the end of therapy. If I've done all the processing and there's still stuff left then I know there was neonatal stuff. Maybe I'll go looking for some it, but we're talking about a small number of clients. It's just something I want to be aware of. If you find that someone had to be in an incubator, during the first year of life, you do not have to start with, "bring up the incubator." The perception they develop because of that experience may be of feeling a burden, not good enough, or that they can't succeed. These perceptions are gong to develop as a result of the family interaction because the family is scared and overprotective. Because of the perception they develop based on the family interaction, they may have feelings that they were damaged. Well they were. This is true. They were damaged at the time. This is a true statement. But when they bring up the picture of their family's interaction, how does it feel to them NOW? (The irrational belief they develop because of their situation and the family's response) That's the dysfunctional material that has to be processed.

FAMILY SYSTEMS - do a geneogram. That's a nice thing that Kitcher introduced to a lot of clinicians as a means of history taking and target identification. So this illustrates how we can draw from various orientations what we can possibly use within the EMDR approach. Transference, cognitive beliefs, timelines, geneogram, etc. are all valuable tools for us to consider utilizing during history taking.

EXPERIENTIAL - SOMA: How did you feel the last time it happened? Notice where you feel it in your body. Think back in childhood. When's an earlier time you felt this way? This gives you earlier targets. (The Float back technique)

Can you target the present stressor? Yes. But, remember, the disturbance may go down; or it may go up. You're counting on the channels associated with our target node to reprocess (our Adaptive Information Processing

Model). If the channels don't process, we may be left with the present situation that's more difficult to close down. Or if it's not moving, it may be because the earlier experiences are feeding it. Or if it becomes far more intense than our client and we expect, based upon the selected present target, we may have unknowingly opened up a more traumatic feeder memory that was underlying our present target. A feeder memory we failed to identify during history taking. That's why we usually suggest, "Go to past first."

Now having said that, what if someone was recently raped? Do we always go to past first? No! You have a recent rape survivor. And while this represents a recent PTSD situation, it's still valuable to identify whether there were other sexual assaults or traumas in their life. It is important to identify everything that has happened, so get a comprehensive history. See if there is a reason to target an early file folder or is it more appropriate to target the recent rape. It may be all you need to do, however, there also may be earlier traumas that are feeding the rape and that are why you should consider going there first. By identifying these past issues and discussing targeting strategies with your client, you are providing informed consent, so if some past traumatic memory emerges while you are processing the present target, at least you and the client are prepared.

FLOATBACK/FORWARD (often helpful during history taking and target identification). Bring up the image, bring up the cognition, notice your body, let your mind float back/forward to times when your have (or anticipate) experienced those cognitions, and/or body sensation. The float back/forward technique also gives you more information and helps in case conceptualization.

PHOTOGRAPHS: Have them bring in pictures from their family of origin, sit down and talk to you about it. Hear what they say about it. Early videos can bring up a lot of stuff. And journal, artwork. In other words, all across the clinical spectrum bring the wisdom of all of your clinical experience, training and therapeutic orientations, into your case conceptualization strategies. The more tools we have to flesh out what particular targets need to be addressed the better. And the more we can learn from each other the better. But as we utilize these various tools, remember, they are being used for finding the targets that need to be processed. The negative ones and the positive ones. We reprocess the negative targets to transform them and we incorporate the positive experiences to enhance the learning that accompanies reprocess.

If a client was traumatized during her earlier years, she passed through various developmental stages, without taking on what she needed; to have the psychic infrastructure to love, to bond, and to have joy. We want to be

able to introduce those developmental deficits into the system. So EMDR reprocessing is processing the negative experiences as well as the positive experiential contributors. The experiential contributors not only dysfunction, but also the experiential contributors to health. So when I hear clinicians say, "I don't use the EMDR trauma protocol," it's based on a misunderstanding. When we first started, we had lots of clinicians who understandably sought the big "T" trauma. Clinicians learned to diagnose PTSD targets. We all can easily see rape, kidnapping, car wrecks and the big "T's" that create negative effects. Equally important, however, is to be aware that just because it's not a "T" these big criteria "A" ones, don't forget about those other experiences, those more ubiquitous ones, the "t" events such as being humiliated in grade school, being pushed away by dad, having these losses, having all these things that go through childhood. Realize they're going to have those negative effects also. And if they still have negative effects, you think of them as a trauma because, by dictionary definition, they had a negative effect upon self or psyche. Think of it as a small "t" trauma. So it is important to think of the EMDR protocol as a reprocessing of dysfunctionally stored memory networks ("T" and "t" events), not just trauma protocol. The Standard EMDR Approach (Past, Present Future, following the 8 phases) is the protocol for processing experiential contributors of dysfunction and health. An Approach that facilitates emotional health and self-actualization.

End of Shapiro Series #8: