

Shapiro Series #3 Francine Shapiro, PhD
Adaptive Information Processing and Case Conceptualization
EMDRIA 2003 – Denver Colorado

Slide #3

Adaptive Information Processing

- A – Adaptive Assimilation
- B – Brain is Part of Body
- C – Connections and Channels
- D – Distortions are to be Avoided
- E – Evaluate Every Experiential Contributor

Pathology is based upon stored experiences. Health is based upon stored experiences

What we are looking at, in terms of the conceptualization, is an adaptive information-processing model, which we used to call “accelerated.” Adaptive information processing is basically looking at the notion of underlying dysfunctional pathologies formed in a memory system that has been unable to be processed. The neurobiological mechanism – which brain part is involved in healing - is the neurobiological underpinnings of any form of psychotherapy. The wonderful research that Dr. Amen showed yesterday was fabulous in that it showed pre- post brain activity, but it didn’t show how the changes occurred. It didn’t tell us what the mechanisms were for change. So the information-processing model is independent of the neurobiological mechanism because the field of neurobiology cannot tell us what causes change to occur. We certainly can’t explain psychodynamic, cognitive or anything other psychological intervention neurobiologically. In fact, at this point it is difficult to explain the results most medications achieve. The Information processing model, therefore is a framework I put it together to explain the clinical phenomena that we were seeing in EMDR practice. And if we look across the spectrum of orientations, this information-processing model can explain the phenomenon that is highlighted in other forms of psychotherapy as well. If we look at insight or psychodynamic interventions, positive treatment effects occur when the neuro-networks (the memory networks) linkup and the more adaptive information links and transforms the other information. As you can see, the memory network framework may be may be viewed as the underlying theory in most psychotherapy approaches.

The types of things that different orientations do to get their treatment and how they look at it are what differentiate them. So this is what differentiates EMDR as an approach to psychotherapy. It’s in the encyclopedias now alongside CBT and psychodynamic, and experiential as a separate approach. The EMDR Approach explains the clinical phenomena and how personality develops. As an assimilation and accommodation of experiences and memories.

The EMDR Approach also predicts positive treatment outcomes. On the basis of this model I was suggesting that people try it with phantom limb pain because it would seem to me that phantom limb pain would be the stored somatic memory. Since there would seem to be no medical cure, what if it was the stored somatic memory causing the phantom limb pain? If you processed the stored somatic memory, would the pain go away? Well, guess what, that's what it does. Successful predictions in treatment outcome based on the model reinforce the model. It also gives us more information about the model per se, what we can expect to have good treatment effects and what we can't. Let me underscore one important point - predicting that we CAN and seeing in clinical practice that we CAN – is different than demonstrating that we DID. So it's a multi-step process out there.

The EMDR Approach and the Adaptive Information Processing Model guide case conceptualization and procedures. I've heard clinicians give a description of a case and say at the end of it, "I don't know what technique to use." Well first you've got to conceptualize the case via the information-processing model and that will tell you what the targets need to be and it will tell you what you have to do to prepare the client. And then you go step-by-step through the client's case. If you don't do that with an overriding sense of how to conceptualize the case, then everything becomes a bunch of techniques that you use with you try to figure out when to use what. It's a basic way of thinking about the entire clinical picture. The basis of it is there's this physical information processing system in the brain and that information has been stored in a way that it's causing dysfunctional responses. So what are we looking for in the clinical picture? The "hot" spots, those aspects that have not been appropriately processed, that is, the memories stored in the associative networks. Do you all remember this?

HAND/FINGERS (Illustration: back of the hand, with fingers pointing down.) The back of the hand representing the target node, the fingers representing the channels of associate networks that need to be allowed to reprocessed before total treatment effects can be achieved)

This is the basis of "What is EMDR?" EMDR is not eye movement. EMDR is an 8-phase treatment approach and the framework in which we see the case is based on the model that memories are stored in the associative networks (fingers) and that these associative networks are the basis of perception, response, attitudes, self-concept, personality traits, and symptoms. Each one of these networks stem from the memories that are stored. Now, yes, there is nature – nurture. There are genetic propensities. There are some people who have nervous systems that will be weaker or more susceptible just as there are some people who will have weaker or more susceptible cardio systems or respiratory systems. Our (EMDR) concept of mental health, therefore, is not to think of what technique we need to use to make a person think or feel better. Our Approach is to look at the client's issues as stored in memory networks. These are memories that are physically stored. Our focus is on how do we

process them. Our goal is to liberate the client from these static brain states allowing them to be everything that they can be. Because currently, they are being pushed into doing things they don't want to do, and prevented from doing things that they want to do. It's because of the brain connection.

Those of us, who have a sense of spirituality, believe in a sense of consciousness, of principles of healing, of love and connection. However, is that the way we go through our life every day? Every moment of every day? Are we always loving? Kind? Patient? Compassionate? We want to be, but something's not allowing us to be – the brain state. So how do we process that brain state so we can be transformed to who we would like to be? So that we're not being pushed in other directions. We'll begin developing our case conceptualization in the slides to come.

End Shapiro Series #3