SHAPIRO SERIES #4
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ADAPTIVE INFORMATION PROCESSING AND CASE CONCEPTUALIZATION
EMDRIA 2003 - DENVER, COLORADO

So, 5 fingers (A,B,C,D, & E) : it's going to be a really quick way for you to go through it in your head - did I remember the principles in dealing with this case?

SLIDE #4
A -- ADAPTIVE ASSIMILATION (FINGER A):
* MEMORIES (INFORMATION) WITH DISTURBING AFFECTS AND SENSATIONS ARE DYSFUNCTIONALLY STORED WITHOUT APPROPRIATE ASSIMILATION INTO LARGER ADAPTIVE NETWORK
* POSITIVE AND NEGATIVE ATTRIBUTES ARE FED BY STORED MEMORY EXPERIENCES
* PERSONALITY TRAITS ARE HABITUAL CHARACTERISTIC RESPONSES BASED UPON STORED EXPERIENCES
* SYMPTOMS THAT ARE NOT PURELY ORGANIC IN NATURE ARE BASED UPON STORED EXPERIENCES
* PROCESSING TRANSMUTES INFORMATION TO ADAPTIVE RESOLUTION

-Memories (information) with disturbing affects and sensations that are dysfunctionally stored without appropriate assimilation into larger adaptive networks. An event happens, it is brought into my system and instead of it being able to link up with other positive things - I'm terrible I'm terrible, but wait a minute, Mother loves me, my dog likes me, I did OK yesterday, things will get better, I've had this before, it'll always pass and it transforms the information to adaptive resolution. When that doesn't happen, it's becomes stuck in its own neural network. It doesn't assimilate or process to an adaptive resolution.

-Positive and negative attributes are fed by stored memory experience. What we need to recognize is that it's not just dysfunction or bad, negative attributes, it's all our attributes. What's makes up our ability to be compassionate, the ability to love self and others, strong or good feelings about ourselves, are the positive experiences we've had that have linked together and formed our personality traits, our sense of self. So it's not just negative; it's also positive experiences. So what we're trying to do with EMDR is access the negative dysfunctionally stored memory networks so we can move them toward health. It's not that we're yanking out the memory or purging the memory. We're not purging the memory. We're catalyzing a processing system that allows that memory to transform. Learning is taking place. It's linking up so that appropriate information is being brought the information in - not only here - but to consciousness. So it's a full transformation of on all levels.

-The personality traits are habitual characteristic responses based upon stored experiences meaning when you hear folks say "well he/she has a personality disorder and it's never going to get any better" you're looking at a monolith here - it is hard to move Mt. Everest from one place to another. If however, you look at "what do we mean by personality-disordered person, besides we don't like him as Dr. Amen said yesterday, Is that there are characteristics that this person has that we classify as a constellation and we describe as this particular disorder. The constellation means that individual's characteristics - each personality trait is a characteristic response in the world. I usually respond in a certain way - why do I respond in that way? Because the previous experiences I've had have linked into an associative network and I characteristically do this or that, and it becomes a personality trait. If I have enough of them they form into a cluster, and you're going to give it (me) a disorder. But don't look at it as a disorder. Instead, say "OK, so these are the indications of the kinds of things that I might look for but no 2 clients with the same disorder are going to have the same personality! It's on a spectrum and each characteristic is addressed separately. It's not that I'm treating a borderline personality disorder. I'm treating someone who has fear come up and doesn't know how to deal with it and reacts in an angry fashion when certain things happen and can't stay in relationships. What am I going to do about that part? So for each individual, we're looking at "how do they characteristically respond in a way that's not healthful and what can I do about that?"

-Symptoms that are not purely organic in nature are based on stored experiences. Yes, there are purely organic symptoms. Certain forms of depression require lithium in order to rebalance neurological salt. Some types of depression, may need certain types of medication to get certain brain activations occurring but in many instances what you've got are experiences that told the person they are helpless and hopeless and if you process those there's no longer a depression.

In other situations you may have a genetic propensity towards that reactivity but it's the experiences that have come in that have tipped the boat. Processing the experiences allows the system to settle down and they won't be reacting in that manner. We have lots of anecdotal reports of clinicians working with clients having bipolar disorder. but we have nothing in the literature of working with bipolar disorder so theoretically, yes it makes sense, and in my conversations with Dr. Amen, I gave him the choices of bipolar disorder and what about the notion that it had the genetic propensity and experiences cause it to tip over and he agreed that's the way he believed as well and this gives you as the EMDR clinician the opportunity to be able to work with your client to be able to identify "is it genetic? Organic? Or is it experiential? But you shouldn't be going out

looking for your first bipolar disorder client, or schizophrenic client. The use of EMDR needs to dovetail with the specialty wisdom of that field. You need to be educated in whatever specialty area you're working with and then you can integrate EMDR to what you know about that system. And when we're talking about standard protocols in EMDR and not deviating from it, we're talking about during the reprocessing, making sure that procedures are done but not in isolation.

It was a beautiful example that Karen Lansing was giving yesterday of having used the standard protocol to work with a policeman that was getting the results that Dr. Amen was showing with a brain scan. She used the standard protocol with three additions she added in order to help access the information that needed to be processed. And her understanding of the police allowed her to put those additions in which would be different than the additions someone might work with a firefighter or with a sexual abuse victim or with a phobia client or a substance abuse client - whatever it might be. That's fine. Those are your additions. It's when people go "well I don't use the negative cognition" or "I don't use a positive cognition" and "I don't really process it" or "we talk about it and do eye movements." This isn't EMDR.

And just to underscore the notion - just so we're clear - way back 8 years ago, I was told by some folks that called me in Oregon that there's this therapy out there that they're calling Rapid Eye Therapy that they're hooking up and connecting to EMDR research. And they're not teaching it to licensed professionals; they're teaching it to anybody that has $3500 to pay. Now this is not saying that these are unethical people. These are people who believe that they have something good and they don't believe that psychotherapy should be done only by licensed mental health professionals but anybody should be able to do this and this is why they're doing it and so they're adding in NLP anchor points and have formations and eye movements and it's called Rapid Eye Therapy but it's not EMDR. It's not using the procedures and the protocols and the safeguards and it has nothing to do with the research that's been accumulated. But it's the same thing folks. If you're putting head phones on someone and talking to them, that's not EMDR. See? A lot of things that you can do may be great but adding bi-lateral stimulation to them doesn't make them EMDR. So whatever you're getting has nothing to do with what Dr. Amen showed you. And what you're getting has nothing to do with the research base. And that's what Rosalie meant when she said for ethical informed consent, you need to be using EMDR and, yes bringing in your creative strategies and your wisdom but if you don't go back to the processing, if you don't use the standard protocols for processing, the 8 phases, the procedures, it's just not EMDR, OK?

So the notion of adaptive assimilation is how do we prepare the clients to do the processing and how do we know it's done with the recognition that

what we're trying to do is finding the targets that need to be processed so they can move into the adaptive networks. Now yesterday we had the brain in the plenary and tomorrow we're going to have Peter Levine doing the body, the somatic experience and I get to be the sandwich here with the concept that the brain is part of the body. The notion that it's not just up all here, but because it is part of the body and it can be looked at as being run by the same principles and that if information processing is physical, it's intrinsic, it's adaptive. We're talking about a physical system. That's what we're looking for in EMDR. How do I stimulate this system which is physical, intrinsic and adaptive? It's geared to take disturbance to mental health. It's healthy and it's physiologically based. Yes, there are exceptions - 25 years of daily cocaine use, meta-ampetamine use - you may not have the health information processing system but by and large, for most of our clients we are dealing with a healthy and physiologically-based system that's geared to go to health.

Physiological memory networks interact to produce psychological pathology or health so it's not a disease model we're looking at; it's a health model. How do we have the information transformed? When I process this information, these manifestations of that rape experience I don't want a client in the end who goes, "Oh yeah, it doesn't bother me anymore." That's it. What good is that? She went through an experience. How can she learn from that experience? What sense of self is engendered from that experience? For her to go from here and then move through processing to "you know I have a new definition of self. I want to help others not have to go through this. If it happens to someone else, I can talk to them, explain, show compassion, movement, transformation in a positive direction. Not just the equivalent of a pre-frontal lobotomy.

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