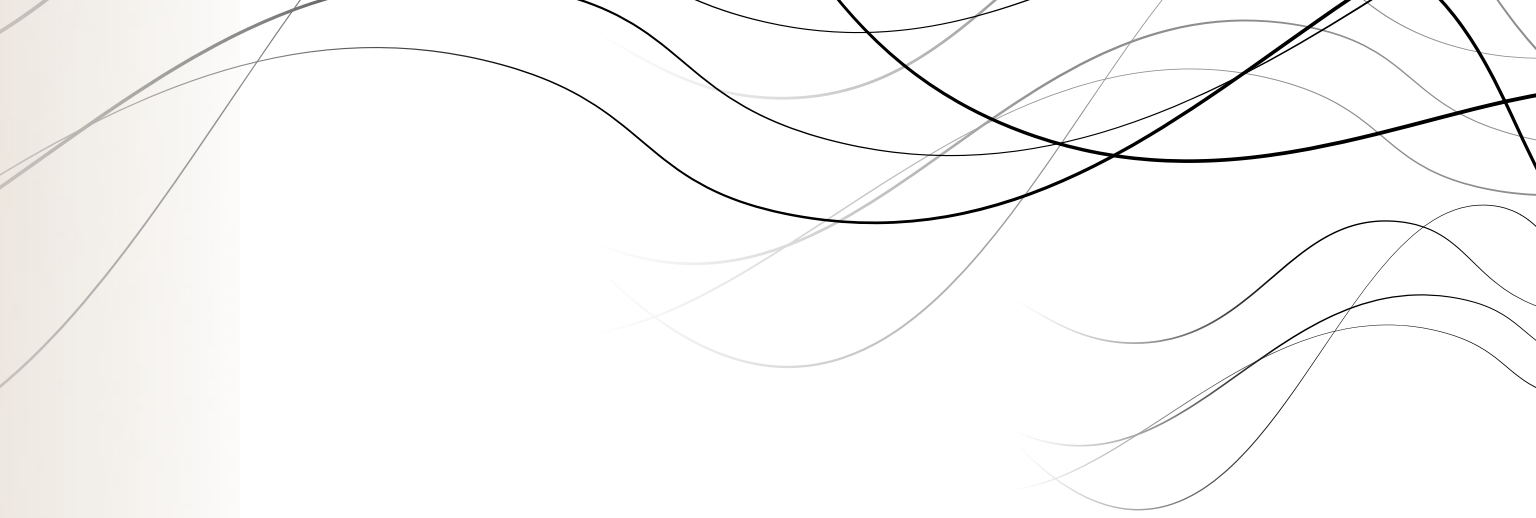




AIP CASE CONCEPTUALIZATION: Easier Said Than Done?

By Deany Laliotis, LCSW

The past is present for better and for worse is the essence of the Adaptive Information Processing (AIP) model of Eye Movement Desensitization and Reprocessing (EMDR) therapy. That means our experiences in the present are informed by our experiences in the past. When those past-present connections are emotionally confusing and/or disturbing, they have a negative impact on us. As EMDR therapists, we learned to identify and reprocess these memories from the past that are similar in one or more ways, to the client's experiences in the present by applying the Standard Protocol. Once the past memories

are resolved and the present-day situations are no longer triggering and confusing, we apply a Future Template to ensure that the client has more adaptive ways of thinking, feeling, and responding going forward. While offering symptom relief is always important, it's also about developmental growth and change. Using a developmental lens to supplement our AIP understanding of what the problem is allows us to not only identify and reprocess relevant life experiences, it also offers a map that helps us fill in what's missing. It's elegantly simple; it can be replicated, and it works. But often, it's more complicated than that as we humans are much more than the sum of our

memories. It's about who we become in response to our life experiences that help define who we are.

Most of us learned a symptom-focused approach to EMDR when we were first trained. This is particularly useful when we are treating Post Traumatic Stress Disorder (PTSD) based on a single event or episode. The onset of the symptoms is directly correlated to the event itself, so treating the symptoms offers clients the necessary relief from their PTSD. After all, the goal for the treatment of PTSD is symptom resolution, so clients can pick up their lives where they left off before the traumatic event occurred.

Most often, however, the case is more complex, so the conceptualization is not as straightforward. If a client's predominant symptom is anxiety about giving a performance, for example, we are looking for one or more bad performances in the past that would explain anticipatory anxiety about the future. Is it that simple? Sometimes, but it's usually more involved than identifying a similar type of event that occurred. So, in addition to asking about what happened, we also need to understand *why* it keeps happening in the present. Asking "why" directs us to the client's lived experience in the present. Are they reacting with anticipatory anxiety because they're *not good enough* out of their sense of inadequacy? Or is it because they're *feeling unsafe* and they are afraid of getting in trouble if they don't do well? Or is it because they feel that they're *not in control* despite their attempts to control themselves and the situation? If we're also curious about *why it's happening now* in addition to what happened, it leads us to the client's experience of self in the present, which informs the types of memories that need to be reprocessed. Many trainers and clinicians refer to this as a belief-focused treatment plan (see van Pelt, et.al. 2025) that is focused on shifting the core dysfunctional beliefs about the self. Most often, however, particularly with clients who have complex trauma, the treatment plan isn't organized around one negative belief, but more likely, all three categories, depending on the context.

IT'S NOT ABOUT WHAT HAPPENED. IT'S ALSO ABOUT WHAT HAPPENED.

For example, I had a client who struggled with anger and would frequently lose his temper, causing him to lose his jobs, and ultimately, his

relationship with his family. When we floated it back, we arrived at a foundational memory of being forced to witness a young cousin being brutally raped. One could readily conclude that the trauma is about the assault. Often, however, it's not that simple. In this case, it was more about the meaning he had assigned to his experience. The Negative Cognition (NC) was, "I'm a failure," which made sense because he felt guilty that he didn't protect her from the assault. What became clearer was that the experience of being powerless then became the basis for his anger now. While it was true that he felt guilty, it was the powerlessness that was the root of the "why." His response or *adaptation*

until we went back and targeted the experience of powerlessness that was still disturbing to him and perpetuated his anger. Ultimately, he learned that having power was to be in control of himself, rather than trying to control other people and situations.

While it's important to understand the past experiences that are similar to their current situation, it's also about *what clients learned to do in response to what happened*, which now has a life of its own, independent of the root causes of their current difficulties. AIP is also a model of learning. While we can target similar experiences, we also need to target the maladaptive learning that came about as a byproduct of these

If we circle back to the notion that the past is present, what that also means is that we are targeting the client's lived experience in the present about what happened in the past. This is an area of confusion for many of us as EMDR therapists who are focused on what actually happened in the past rather than using the client's experience in the present about what happened.

to his failure was to ensure that he was always in control, using anger as a means of establishing a power-over position with others in the same way he was rendered powerless by the man who raped his young cousin. Further, instead of being fearful of being hurt himself, he became the perpetrator, defending from his sense of vulnerability that he, too, could be hurt. The memory was not resolved

unresolved experiences that are now problematic for the client.

I am reminded of Helen (pseudonym) whom I worked with adjunctively for several months who presented with anxiety, low self-esteem, codependency behaviors, and misophonia, a hypersensitivity to certain sounds. As with many of our clients, she presented with a number of symptoms that manifested

in a variety of different contexts. As a result, there was more than one pathway between the past and the present. She had been working with an experienced EMDR therapist for many months and had reported significant improvement in her self-esteem and was less anxious overall. Using the Standard Protocol, they had targeted Helen's foundational memories of growing up in a family where the parents fought a lot, and as the oldest of three, she was protective of her two younger siblings. As a result, Helen became overfocused on them and less concerned about herself. As part of her therapy, Helen learned to be less anxious and responsible for others. Meanwhile, the misophonia symptoms persisted, and they were at an impasse in the treatment, which is when Helen's therapist reached out to me. I met with Helen, and listening

The clinical challenge is to keep our eye on the big picture, which is our case conceptualization, as that informs our Target Memory selection...

with my AIP ear, I was curious to better understand *why* Helen developed misophonia of all the symptoms one could develop in her family situation. *If there were a good reason for the onset of her misophonia, what would it be?*

As it turned out, there was a good reason indeed. Her hyperacuity to sound developed in response to her need to be in control of an out-of-control situation by listening in on what her parents were arguing

about. This served to soothe her anxiety in a situation that would otherwise have been too scary, particularly since she felt responsible for her younger siblings. So, instead of targeting a memory of their fights, with the negative belief of "I'm not good enough" because she couldn't protect her siblings from the fighting, we targeted a representative memory (it happened a lot) of standing against the closed door

On-Demand

"Transcend"
your EMDR practice today
with

3.5 ECs

Case conceptualization to reduce re-work of target plan

Helps to prevent "blocking beliefs" or "protective parts" from taking over sessions

Transcendence
EMDR Based Approach

All components truly personalized for each client

Integrative approach leading to more memory recall and lasting effects



Integration of EMDR, Schema, Somatic, IFS, & Narrative Principles
By Kristi LeBeau-Cline, LPC

Learn more: <https://lebeaulove.com/continuing-education>



of her parent's bedroom with her ear glued to the door, listening in on what they were fighting about. What was also tricky about this Target Memory was that listening at the door was not disturbing to Helen. It

she listens for everything, whether she wants to hear it or not. So, as a result of her emotional need to know by listening to everything that was happening at the time, she became unable to filter out sounds that were

the groundwork for the client's current difficulties as they have memory networks of their own. Helen's hyper-acuity to sound gave her the illusion of being in control which helped her cope at the time but now was intrusive for her and a challenge for others around her. Distinguishing the symptom from the problem requires us to be less focused on *what* happened and more interested in *why*. Focusing on why it occurred offers a more holistic view of the client's current difficulties in a way that informs more accurate Target Memory selection and in doing so, optimizes our treatment outcomes.

From Dr. Francine Shapiro's perspective, negative beliefs about the self are verbalizations of stored affects that crystallize sometime after the event occurred. Without access to adaptive information at the time, it results in distorted conclusions about ourselves and our role in these painful and confusing experiences. When these experiences happen too often, however, these conclusions take on a life of their own, having a negative impact on the client's overall sense of self and sense of safety in the world, as well as having a sense of agency to act on one's own behalf.

AIP case conceptualization is a dynamic process, not a static one. It, too, evolves over time as our clients change. Our formulation can be as simple or as complex as our clients.

wasn't disturbing then, and it wasn't disturbing in the present. It reduced her anxiety to "know" what was going on.

If we circle back to the notion that the past is present, what that also means is that we are targeting the client's lived experience in the present about what happened in the past. This is an area of confusion for many of us as EMDR therapists who are focused on what actually happened in the past rather than using the client's experience in the present about what happened. So, in Helen's case, she didn't mind listening to the sounds; she minded that she was powerless to control their fights. So, when I asked her to identify the worst part of the memory in the present, it was her parents relentless fighting that generated anxiety. The sounds of their fighting made her feel out of control, so the negative belief was, "I'm not in control," as she pictured herself as the 12-year-old in that situation.

Once we understand the *why* of the symptom, it brings us to the problem. Not only did Helen learn to listen in on her parents' fights, now

not important for her to hear, such as the sounds of someone chewing. So, the need to be in control had to be redefined, so Helen could choose what to listen for and what she could tune out. The case conceptualization helped us pull the thread from the past experiences with her parents to the present experiences with people chewing or background conversations at work and was able to successfully filter out noises she now deemed to be unimportant.

Another way to think conceptually using an AIP lens is to consider that a client's symptoms developed in response to a set of experiences that helped the client cope at the time, but now that coping strategy is at least overdeveloped, likely obsolete, and now problematic. These adaptations to unresolved trauma are characteristic patterns of response that are now habituated and need to be targeted separately in addition to the foundational memories that set the groundwork for the client's current difficulties. Often, we need to target the present-day situations in addition to the foundational memories that set

THE ABSENCE OF THE NEGATIVE DOESN'T NECESSARILY TRANSLATE INTO THE POSITIVE

With clients who suffer with complex trauma, it's not enough to bring resolution to painful memories because they're often struggling with what they missed out on developmentally while they were surviving their childhoods. AIP case conceptualization not only informs Target Memory selection, it also informs the interweave strategies we use to facilitate developmental growth and repair. In Helen's case, it wasn't enough to accept that she is not responsible for other people's welfare and that she cannot control

others' actions. She needed to develop her self-identity apart from those roles and assume control over her life and her experiences.

Here is an edited excerpt from the session when we targeted where she stood by the closed door, listening. After going through the arousal—de-arousal cycle of processing the freeze state, what happens next? For Helen, it didn't come naturally because the information is missing. AIP informs us that the client needs access to the adaptive information if it doesn't already exist in another memory network. Our role is to ensure that the client has access now, so we need to extend the invitation once the negative information is successfully processed:

Helen: *I'm sad for my younger self that I had to be around that.*

Therapist: *Go with that. (BLS)*

Helen: *I wonder, why is my impulse to go towards the fighting, rather than away from it?*

Therapist: *Go with that and stay curious about it. (BLS)*

Helen: *I'm feeling frozen at the door, like I can't move.*

Therapist: *Notice the freeze, notice where you feel it in your body. (BLS)*

Helen: *I want to move away from it, but I can't.*

Therapist: *Notice the impulse to move away, while at the same time feeling the freeze in your body. Just track your sensations and give your body the opportunity to do now what it couldn't do at the time...would that be okay?*

Helen: *Sure.*

Helen (after a long set of BLS):
Very cool, crazy feeling...

Therapist: *Can you describe it?*

Helen: *I haven't felt this before. I can feel my brain totally pause. I was fixated on that door and the sounds behind it. I was thinking about how I can walk away. (Pause.) I'm feeling the freeze lifting now.*

Therapist: *Great, stay with it. Take your time. (BLS)*

After several sets of BLS, we returned to the Target Memory:

Therapist: *When you bring to mind what remains of that situation, what is your emotional response in this moment about that moment?*

Helen: *That it wasn't okay to be exposed to their fighting.*

Therapist: *Of course. Go with that! (BLS)*

Helen: *Now what do I do?*

Therapist: *Would you be willing to be curious about that? (BLS)*

Helen: *I'm trying, but nothing is coming to mind.*

Therapist: *Would it be okay to ask your body what it wants to do now that it couldn't do at the time and notice what comes up? (BLS)* Client nods.

Helen (after some time): *I want to walk away. I don't want to know about*

it, I don't want to hear it. And I don't deserve to be subjected to it.

Therapist: *Okay, notice that you can choose what you want to do now that is best for you. Notice what it's like in this moment. (BLS)*

Helen: *I feel free to be myself.*

As illustrated in this passage, the predominant theme of power and control is the thread that is offered through the interweave strategy, particularly when Helen was invited to consider what she wanted to do for herself now that she had the option. Once the freeze response was processed through, there was space for Helen to redirect her attention from what was going on around her to what was going on inside her, shifting the locus of control which is the developmental challenge. It's also the adaptive information that the client didn't have at the time that we make available now that the client can learn new, more adaptive ways of responding.





The invitation by the therapist to be curious in that moment empowered Helen to choose herself, which was not a choice that was previously available to her. Future templates were applied by creating new neural pathways of desirable responses to challenge situations in her life to ensure that Helen had the emotional flexibility to respond adaptively based on the current context of her life.

As with many clients who have complex trauma, there are multiple themes, multiple symptoms and multiple issues in a variety of contexts, which is one of the many reasons why AIP case conceptualization can be illusive. The clinical challenge is to keep our eye on the big picture, which is our case conceptualization, as that informs our Target Memory selection as well as our interweave strategies. The reevaluation phase is, in my experience, the most efficient way to stay focused on the big picture. This dynamic phase of our model offers us an important opportunity to circle back to *the client's lived experience in the present* and how that is shifting based on the work. Asking about the micro changes as well as the more remarkable ones makes the changes explicit, rather

than just the absence of the negative. The client is invited to be in relationship to themselves as well as their changes, taking greater ownership of who they are becoming. It also gives us an important opportunity to ensure that we are tracking how the client's self-identity is evolving based on their day-to-day experiences of self and other. Taking an active interest in how the client is growing and changing allows us to go beyond symptom relief and stay focused on the big picture of how they are showing up in the present and how they would like to be able to be in the future.

AIP case conceptualization is a dynamic process, not a static one. It, too, evolves over time as our clients change. Our formulation can be as simple or as complex as our clients.

EMDR has evolved beyond the 10 worst things that have ever happened to our clients. It is now a comprehensive psychotherapy approach that can treat a broad range of clinical issues.

While offering symptom relief is always important, it's also about developmental growth and change. Using a developmental lens to supplement our AIP understanding of what

the problem is allows us to not only identify and reprocess relevant life experiences, it also offers a map that helps us fill in what's missing, allowing our clients to shift from surviving to thriving. After all, isn't that what it's all about? ●

Deany Laliotis, LICSW, is an internationally recognized thought leader, who teaches EMDR therapy using an attachment-informed approach for treating complex trauma. As the founder of The Center for Excellence in EMDR Therapy, she offers a continuum of trainings from the basic through master courses, offering a Master Certificate in Relational EMDR Therapy. She worked closely with Dr. Francine Shapiro since 1993 and was her director of training for more than 10 years. EMDRIA™ awarded Laliotis the Francine Shapiro Award for Outstanding Service and Clinical Excellence in 2015. She has authored and co-authored several book chapters and articles on EMDR and is currently writing a book on Relational EMDR.®

References

- Laliotis, D. (2010-2026). *Healing the Wounds of Attachment and Rebuilding Self: An Advanced Clinical Course for EMDR Therapists*. The Center for Excellence in EMDR Therapy. EMDRIA-approved Course. Live, Online.
- Laliotis, D. & Korn, D. *Clinical Interweave Categories*, (2024), in *EMDR Primer: From Practicum to Practice* (4th Edition)(2024), Hensley, B. Springer Publishing.
- Shapiro, F. (2018). *Eye movement desensitization and reprocessing: Principles, protocols and procedures* (3rd. Edition). Norton & Company.
- van Pelt, Y., de Jongh, A., Broeke, E., Hornsveld, H., Oppenheim, H., Weijermans, J., Luber, M. (2025). *A practical guide to EMDR therapy: Case conceptualization and additional treatment strategies*. Springer.
-