EMDR Case Formulation Tool

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This article describes a diagrammatic clinical tool to be used when formulating cases in eye movement desensitization and reprocessing (EMDR) therapy. Based on the Adaptive Information Processing (AIP) model, the EMDR Case Formulation Tool is a way of illustrating psychological difficulties, mapping out the relationships between six key elements: unprocessed traumatic experiences, triggers, intrusions, negative beliefs, and symptoms, as well as resilience. From the diagrammatic formulation, a narrative formulation can be developed. The case formulation tool can be shared with the client, used to guide treatment planning, in supervision, and in case consultations. The use of the tool is explained and its clinical applications demonstrated with case examples.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; case formulation; case conceptualization; Adaptive Information Processing (AIP); clinical tool

It is widely accepted that case formulation or case conceptualization (the two terms are generally used interchangeably) is the cornerstone of psychological therapies. It is the process through which the therapist and the client collaboratively make sense of the client's difficulties (Johnstone, 2011) and this is then used to inform clinical practice. Simply, a shared formulation gives the therapist and the client a *map* of where the client is at now, where they have been and how they got here, and where they are going and how to get there.

Case formulation aims to describe a person's presenting problems and uses theory to make explanatory inferences about causes and maintaining factors that can inform interventions. Different therapeutic approaches (e.g., psychodynamic, cognitive behavioral, or systemic) have their own take on the purpose and the process of formulation (Johnstone & Dallos, 2006) as does the Adaptive Information Processing (AIP) model, which underpins eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2018; Shapiro & Laliotis, 2011; Shapiro & Maxfield, 2002; Solomon & Shapiro, 2008).

AIP Case Formulation

Case conceptualization is as important in EMDR therapy as it is in any other therapy modality. At some level, as EMDR therapists, we all formulate our clients' difficulties; however, we do not always make this formulation an explicit process that is shared with clients, as it is in other therapies such as cognitive behavioral therapy (CBT). The AIP model provides a solid basis from which to formulate cases (e.g., Shapiro, 2007; Solomon & Shapiro, 2008).

So, what might case formulation according to the AIP model look like? The AIP model (Shapiro, 2007, 2018) posits that when there is a failure in adaptive information processing (perhaps due to excessive distress, physiological arousal, or dissociation), life events are not processed and are thus stored in their original form (with associated cognitions, affect, and sensory perceptions) in maladaptive memory networks. A whole range of experiences are hypothesized to form these maladaptive networks, such as disturbing life events (small "t" traumas), for example, as a child getting lost in a supermarket, being teased by peers, or wetting oneself in school; as well what are more commonly recognized as traumatic experiences (large

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"T" traumas), such as sexual abuse, road traffic accidents, or the death of a parent (e.g., Shapiro, 2001). These unprocessed memories are understood to be disconnected to other memory networks, therefore disconnected from adaptive information. These memories are stored in a raw form, alongside the original emotions, physical sensations, and beliefs. This conceptualization has parallels with implicit and explicit memories in Brewin's dual representation theory of posttraumatic stress disorder (PTSD; Brewin, Dalgleish, & Joseph, 1996).

The unprocessed nature of these memories means that they are easily activated by current triggers that match an aspect of the original experience. Triggering stimuli can be external (e.g., the color red, the smell of body odor, hearing a loud voice) or internal (e.g., the sense of fear, a certain bodily position, a specific pain). These matching stimuli trigger the identical emotions, cognitions, physical sensations, and behaviors that were present at the time of the original event (Shapiro, 2018). These are experienced by traumatized clients as distressing symptoms, such as intrusive memories, flashbacks, nightmares, fear, shame, and physical manifestations of anxiety. Thus, "the continued influence of these earlier experiences is due in a large part to the present-day stimuli eliciting the negative affects and beliefs embodied in these memories. [. . .] the lack of adequate assimilation means the client is still reacting emotionally and behaviorally in ways consistent with the early disturbing incident" (Shapiro, 2018, p. 16).

"In this way, when the past becomes present and patients react in a dysfunctional manner, it is because their perceptions of current situations are coloured by their unprocessed memories" (Shapiro, 2014, p. 73). Thus, a history of earlier unresolved trauma creates dysfunctional memory networks that compromises one's ability to cope with current crises.

These unprocessed memories are also activated in the absence of stimuli, for example, in nightmares and in spontaneous intrusive memories. This can be seen as a natural attempt at processing this information that gets disrupted because the memories are so disturbing. The intrusions of these unprocessed traumatic memories can range from an overwhelming experience such as a flashback to a barely noticeable memory that nevertheless affects current experience and behavior (Hase, Balmadeda, Ostacoli, Libermann, & Hofmann).

Hase et al. (2017) suggest that these memories can be usefully understood as pathogenic memories; that is, memories that are experienced as intrusions when the memory is activated, which is accompanied by physiological arousal and disturbance. They argue that pathogenic memories have a central role in a range of difficulties, not just PTSD, which is in line with the AIP model. As unprocessed traumatic memories are activated, the associated negative beliefs or cognitions that are still *currently held* are also activated in the *here and now*. These negative cognitions can be organized into four main domains around safety, control, responsibility, and self-defectiveness (e.g., Shapiro, 2007). For example, someone who is constantly re-experiencing a sexual assault has the currently held belief "I'm not safe"; someone who was sexually abused may believe "It's my fault; I deserve bad things."

According to Hase et al. (2017), these currently held negative beliefs and the intrusive memories cause a whole range of other difficulties, which will vary across presentations and conditions. For example, in some cases there is a PTSD presentation, including avoidance of any stimuli associated with the traumas, symptoms of hypervigilance due to the present sense of danger, and dissociation as a survival response to overwhelming experiences. In cases of obsessive compulsive disorder (OCD), there may be obsessive ruminations or compulsive rituals. In body dysmorphia, for example, symptoms might include a distorted sense of the body or a body part. Or people may present with a combination of these. In addition, the unprocessed memories may manifest themselves in other difficulties, which may be understood as secondary, such as depressive mood and anxiety, and maintained by behaviors such as not going out, substance misuse, or self-harm. Some of these can be understood as attempts at coping; for example, substance misuse as an attempt at self-medication to dampen the distressing flashbacks and to help with sleep. The negative cognitions can be seen as underpinning some of these difficulties. For example, "I am a bad person" underpins depressive feelings and "I am in danger" underpins anxiety.

According to the AIP model (e.g., Shapiro, 2018), the current symptoms result in present fears, situations which are currently feared and avoided and future fears, situations which are anticipated as fearful in the future. For example, let us say that the unprocessed memory of a rape is triggered by someone hearing footsteps close behind while walking home at dusk. This causes a flashback of being held down, which is experienced with the sensation of pressure in the chest, the smell of alcohol and body odor, the emotion of fear, and the beliefs "I'm in danger" and "It's my fault, I should have stopped it." As a result, a whole range of difficulties may be manifested and maintained in the present including avoidance of going out,

especially in the dark, mistrust in people, high levels of hypervigilance, and high levels of generalized anxiety. These may feed into low mood and low self-esteem including feelings of failure and shame. In this case, a current feared situation might be going out at night and a feared future situation might be going on a date or on a vacation.

As illustrated here, the AIP model provides a comprehensive understanding of how current difficulties are the result of unprocessed past traumas. Shapiro (e.g., Shapiro, 2006; Shapiro 2007) has given many examples of how the AIP model can be used in case conceptualization; for example, the case of Tara who presented with excessive anxiety, panic attacks, and pronounced school phobia, whose difficulties, within an AIP model, are understood to stem from unprocessed memories of earlier childhood where she'd felt vulnerable, experiences compounded by her mother's overprotectiveness (Shapiro, 2007).

The EMDR Case Formulation Tool: The Six Elements

In supervision and in case consultation, I am frequently asked, especially by therapists trained in CBT, how to formulate within an AIP model and how to capture an AIP formulation in a visual way that could easily be shared with a client and in supervision. Shapiro's AIP model, as thorough as it is in case conceptualization, is not that easy to use for a quick and practical case formulation. For lack of a better alternative, therapists often used Ehlers and Clark's (2000) cognitive model of posttraumatic stress behavior. However, the model, as useful as it is for CBT, does not have a particularly good fit with the AIP model and EMDR therapy. There lacked an appropriate tool in my clinical practice, as well as in supervision.

The EMDR Case Formulation Tool was developed as a way of capturing and simplifying the AIP approach to case formulation using a visual diagram and a narrative formulation. Drawing a visual representation of the case conceptualization is a useful way of capturing the carious elements and how they relate to each other. A diagrammatic case formulation is also useful for sharing the therapist's understanding of the client.

The EMDR Case Formulation Tool is based on 6 key elements within the AIP model and the relationship between them:

- Trauma (s) (unprocessed traumatic memories)
- Triggers
  - Intrusions (intrusive memories, flashbacks/nightmares, sensory memories including pain)
- Negative beliefs (four domains)
- Symptoms/behaviors/difficulties
  - Resilience factors (positive experiences, positive attachment figures [past and present], strengths, achievements, current positives in life [strong marriage, parenting, career, hobbies])

At its simplest, one could see an AIP formulation as the process of trying to establish the relationships between each of these elements as it applies to each clinical presentation. By drawing possible causative arrows between these elements, one can have a formulation suggesting how unprocessed traumatic memories underpin the psychological symptoms and current difficulties.

Based on this simple premise, the EMDR Case Formulation Tool provides a diagrammatic description of the AIP model and how it informs EMDR therapy, as shown in Figure 1, which can be used as the basis of the case formulation. Before the clinical application of the EMDR Case Formulation Tool is discussed and illustrated with examples, other diagrammatic tools for case conceptualization within the AIP model are briefly discussed.

Diagrammatic EMDR Case Formulations

In a thought-provoking article, De Jongh, Ten Broeke, and Meijer (2010) discussed the process of case conceptualization in EMDR and proposed a two-method approach in which two forms of questioning lead to two types of case conceptualization. They developed a visual diagram to illustrate their method. Broadly speaking, the First Method deals usually with Axis I disorders, including simple PTSD, where memories of the etiological (and aggravating) events can be meaningfully formulated on a timeline. The Second Method is generally used with complex PTSD and/or personality disorders, and identifies memories that in some way form the groundwork under the client's so-called dysfunctional (core) beliefs underpinning the condition. The De Jongh et al. (2010) approach is a useful tool in identifying target memories and making treatment decisions.

Jarecki (2014) developed the "seed to weed technique," a strategy that is based on the AIP model and is used with clients to explain how trauma happens, how past experiences have ongoing impacts, and to monitor progress throughout treatment. This technique

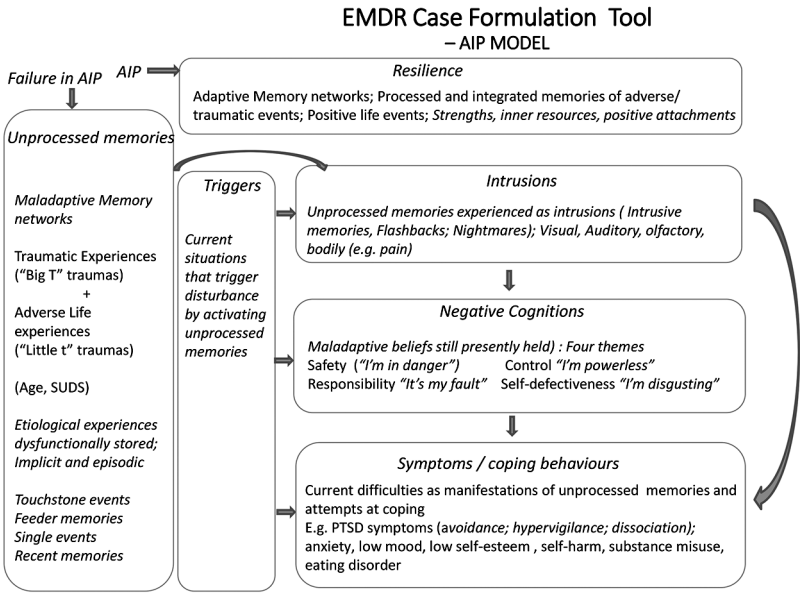

FIGURE 1. EMDR case formulation tool explanatory diagram.
Note. EMDR = eye movement desensitization and reprocessing.

is based on an illustrative metaphor, including visual diagrams, where positive experiences and resilience factors are represented by flowers, fruits, or vegetables, and traumas are represented by weeds (the roots and seeds earlier underpinning memories and the visible parts the more recent disturbing memory). As EMDR processing happens, weeds get destroyed and are replaced by flowers, fruits, or vegetables, reflecting adaptive material. The seed to weed technique can be used to develop personalized case formulations that are developed and added to as the therapy progresses.

Another diagrammatic approach to case conceptualization was developed by Leeds (2017). Leeds describes how, based on the AIP model, a patient's symptoms and pathology are understood as arising as the result of etiological and contributory experiences that contribute to the formation of maladaptive (unprocessed) memory networks. The case conceptualization makes hypothetical links between contributory and etiological experiences, current triggers, and current symptoms and uses this as the basis for target sequencing and treatment planning. The case conceptualization includes identifying the maladaptive memory networks, the current symptoms and defenses, the adaptive memory networks, and the evolution of symptoms over time. Leeds' (2017) approach to case conceptualization is useful for treatment planning and target sequencing.

Each of these visual ways of conceptualizing a case within an AIP model has their strengths and their limitations. All three are useful ways of collaboratively developing and sharing with a client the therapist's understanding of the origins of the difficulties and maintenance of the current difficulties, as well as informing clinical decisions about how to proceed with EMDR therapy. The EMDR Case Formulation Tool is an alternative diagrammatic formulation based on the AIP model. How this tool can be used clinically, with illustrations from clinical case examples, is described in detail next.

Using the EMDR Case Formulation Tool

The EMDR Case Formulation Tool is very flexible in how it can be used. The idea is that the six elements are identified for each case and the relationships between the elements explored. There is a visual diagram that be used to facilitate this process (see Figure 2) but the tool can be used without the diagram, with the therapist drawing freehand the six elements and the relationships between them.

The clinical application of this formulation tool is wide. Clinicians can fill the formulation diagram on their own once they have met with the client after the assessment session, or it can be used to increase a therapist's understanding of an ongoing case . The formulation can be shared with a client as a way of promoting an understanding of their difficulties and the rationale for treatment. The formulation can be used within a session, drawn collaboratively with the client, at any stage in therapy. It can also be used as part of the assessment, guiding the questioning so that all the necessary information is obtained or at a later stage in reformulation. Additionally, the tool can be used in

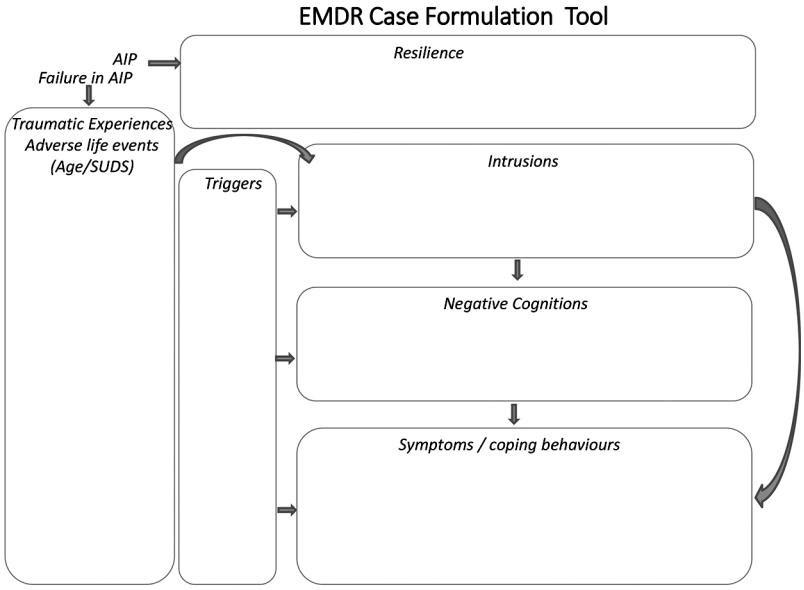

FIGURE 2. EMDR case formulation tool.
Note. EMDR = eye movement desensitization and reprocessing.

supervision or case consultation to quickly and easily share key aspects of a client's history and presentation, to inform case discussion and treatment planning.

The process of doing the actual formulating is also flexible. Therapists can start from left to right by identifying the traumatic memories, triggers, intrusions, negative cognitions, and how this leads to current difficulties; or start with the current difficulties and work the other way, moving from right to left. With complex clients where there are many traumas and disturbing life experiences, it can be helpful to pace the formulation process, using one formulation diagram to depict a cluster of memories; for example, a cluster of all the memories associated with the negative belief ("I'm in danger"), organized by perpetrator (sexual abuse by pedophile ring), or by a time period (tour of duty in Afghanistan). Later on, another diagram may be used to depict the next cluster, and so on.

This tool is broad and flexible enough that it can be used to formulate the whole range of difficulties where EMDR therapy can be used, from simpler presentations such as single event adult onset PTSD or a phobia, to more complex presentations such as complicated grief, complex PTSD, and even personality disorder presentations. It could be used with other presentations such as addictions, chronic pain, or obsessive compulsive disorders. In fact, because of the central role of unprocessed (pathogenic memories), it can be used to formulate any complaints that have these memories at their core.

One important aim of a case formulation is to help to make treatment decisions regarding identifying and sequencing targets, and this formulation tool can help with that process. Several other approaches have been developed to facilitate this process (see Lombardo, 2012) for a discussion of these various approaches. Lombardo (2012)'s EMDR Target Time Line is another approach to developing a timeline of target memories; however, it goes a step further in taking into account how targets can be clustered around negative cognitions, symptom/body sensations, and situation/person/ circumstance, which can inform the treatment plan. The EMDR Case formulation Tool can be used in this way, incorporating as it does a timeline of traumas, which may be organized in clusters. Additionally, though, it links the traumas to the negative cognitions and the current symptoms so that a comprehensive treatment plan can be developed and revised as therapy progresses.

The Narrative Formulation

Alongside the formulation diagram, the clinician may then write and share a narrative formulation of the client's difficulties. It is important to highlight that, in this case formulation, the links between these six elements are theoretical links, assumptions based on the AIP model, and thus, as all formulations, it should be expressed tentatively (as a "best guess"; Johnstone, 2011). The formulation narrative can be done any way it suits the therapist and client. The following is a suggested format:

> One way of understanding your difficulties is that as a result of [trauma(s)] having happened to you, when you are exposed to [triggers] you

> experience [intrusive symptoms] which make you believe [NC] about yourself. This can be thought to cause you difficulties in terms of [symptoms/maladaptive coping]. It makes you fear [present fear] and dread [future fear] happening in the future. Although you have all these difficulties, you have strengths [positive experiences/resilience factors] which give you resilience.

In the above example of the rape, the therapist could develop a formulation narrative that could be shared with the client, in a way that the client could tolerate. The level of detail in the narrative needs to be titrated depending on the client. For quite a resilient client, such a narrative might be as follows:

> One way of understanding your difficulties is that as a result of the rape, when you are exposed to certain situations such as hearing footsteps, being out at night, walking through empty parks, hearing loud male voices, you experience memories of the rape, including the sensations, the pain, the smell of alcohol and of body odour. This makes you believe "I'm unsafe" and you feel a strong feeling of fear. This causes you difficulties in terms of high levels of jumpiness, lots of anxiety, avoidance of going out, mistrust in people, especially men. You are also troubled by the memory of having frozen and not shouting out for help which makes you believe, "It's my fault, I should have stopped it," which makes you feel ashamed and weak and makes you feel depressed. You avoid going out and social situations and are dreading having to go to a family wedding that is coming up. Although you have all these difficulties, you have strengths such as being creative with a strong interest in painting which give you resilience.

Three actual clinical case examples are presented below where the tool was used to formulate a range of difficulties (the clients gave permission for their cases to be written about in this article). As the case examples demonstrate, the formulations can be brief or very thorough and detailed, and additional suggested causative arrows can show the hypothetical theoretical links between the various aspects of the model.

Case Examples

Motorbike Accident (Male, 30s)

The EMDR Case Formulation Tool was used to formulate this clinical case who presented following a motorbike accident. The diagrammatic formulation (see Figure 3) illustrates the case formulation, using arrows to show hypothesized links between the six elements.

Narrative Formulation. A narrative formulation was developed on the basis of the diagram and shared with the client.

> One way of understanding your difficulties is that as a result of the motorbike accident two years ago, when you hear loud noises, sirens or motorbikes and when you smell smoke, it takes you back to the moment of the accident and it makes you believe that you are going to die and you feel extreme fear. As we have discussed, this accident brought back memories of a previous accident where you also felt that you were going to die. Because of this currently held fear and belief that you're in danger, you avoid driving and are terrified of being in a car, you are jumpy, you are constantly in a state of alert and suffer from poor concentration and irritability, which makes you snap at your wife and kids, which in turn makes you feel bad about yourself. You are currently off work as a result.
>
> There are earlier experiences in your life which may be compounding these difficulties. As a child, you were made to feel bad for crying on your first day of school. These same feelings were replayed when you cried in hospital and make you believe that you are weak. You feel ashamed of this weakness. You see your current difficulties as proof of your weakness and feel depressed, guilty, and have low self-worth as a result.
>
> Despite all these difficulties, you have lots of resilience. You enjoyed school and did well and were particularly good at sport. You've built up a successful career which gives you a strong sense of achievement and you have a supportive marriage and family. You particularly enjoy playing football with your kids. Therefore, you have lots of strengths that we can work with.

Complex PTSD (Female, Late 40s)

The EMDR Case Formulation Tool was used to formulate this clinical case of a female client who was referred to an National Health Service secondary care service because of longstanding "blackouts" where she lost consciousness and fainted, which were occurring several times per day, every day (see Figure 4). Organic causes for the blackouts had been ruled out prior to the referral. The client was baffled by the blackouts

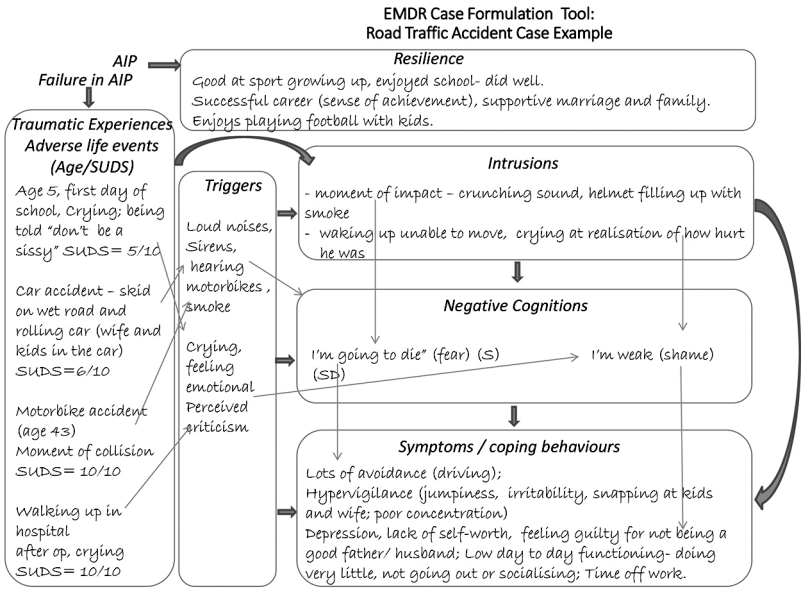

FIGURE 3. EMDR case formulation tool road traffic accident case example.
Note. EMDR = eye movement desensitization and reprocessing.

and her life was extremely limited as a result of the frequent loss of consciouness. The diagrammatic formulation shows some of the hypothesized causative links, but not all of them for the sake of legibility.

Narrative Formulation. A narrative formulation was developed on the basis of the diagram and both were shared with the client a few weeks into treatment.

> As we have come to understand, your traumas started right from birth, with your mother rejecting you because you were not a boy, and thus not a replacement for the son she'd just lost, something that she told you from a young age; she openly preferred your older sister. Your father sexually abused you from age 5 to 11, and you remember your mother removing your sister from your shared bedroom while the abuse was taking place.
>
> It might make sense that as a result of these traumas, when you are exposed to a range of situations, like, experiencing feelings, both negative and positive, weekly calls from your father, the constant and ongoing criticism by your mother even though you visit and care for her on a daily basis, intimacy and sexual contact, they bring back memories of these events and negative self-beliefs that you are worthless and your feelings don't matter, that it must be your fault and you deserve bad things, that you're dirty.
>
> There were further difficult experiences. Your mum remarried but your new stepfather had a psychotic breakdown and was violent and threatening; your mother stayed with him until social services made her leave him. In your teens you were sexually abused by your sister's boyfriend. In your 20s, your sister became terminally ill and your parents abdicated responsibility and made you make the decision to turn off the life support machine. Each of these events further compounded the previous traumas and negative beliefs that you're bad, that it's your fault.
>
> It is perhaps as a result of all this that you experience a whole range of difficulties in your daily life. You experience "episodes" several times a day, which are dissociative seizures in which you lose consciousness. This can be seen as a survival strategy that you developed as a child to cope with overwhelming experiences and this happens now when you need to "numb out" for example, if you experience memories or flashbacks of abuse, if you experience any feelings, even positive ones ("I don't deserve good things"); after you speak to your father, after visits or calls from your mother. You struggle to express yourself and to set boundaries with your family and with people in general. You tend to avoid social situations and live quite a restricted life, including avoiding intimate relationships. You continue to be preoccupied with the death of your sister as the guilt ("I did the wrong thing") has blocked your ability to grieve, and the anniversary of her death and her birthday lead to increased periods of dissociation.
>
> Despite all these difficulties, you are an extremely resilient person. You have a great

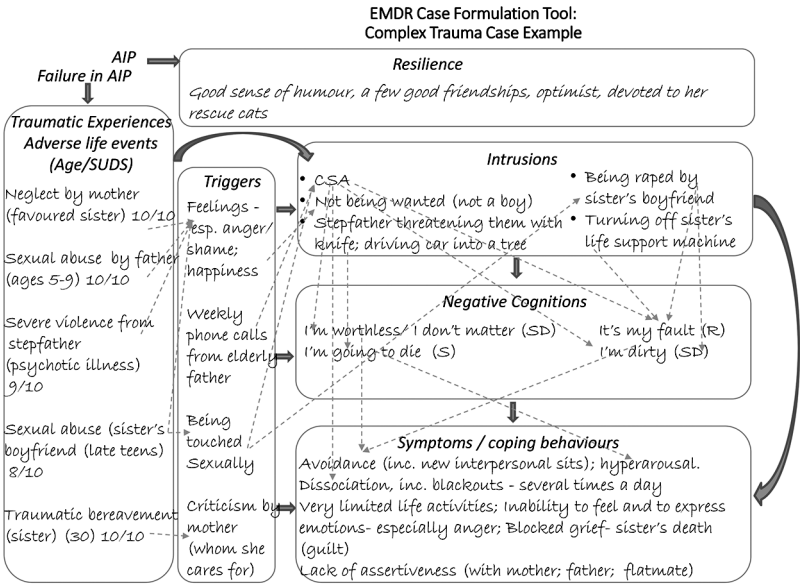

FIGURE 4. EMDR case formulation complex trauma case example.
Note. EMDR = eye movement desensitization and reprocessing.

sense of humor and we frequently laugh in sessions. You are an optimist and able to see the positive side of a situation and of people. You have some good friendships, and you are devoted to the maltreated cats that you have rescued.

PTSD, Emotional Instability, and Narcissistic Presentation (Male, 50s)

The EMDR Case Formulation Tool was used to formulate this clinical case who was referred to secondary care mental health services by his General Practitioner because he was presenting with high levels of distress and who had struggled to engage with mental health services in the past. The diagrammatic formulation (see Figure 5) was developed collaboratively with the client, a few months into the therapy, as a way of trying to disentangle the many facets of complexity in the presentation. (In the hand-drawn original diagram, the hypothetical arrows were present; however, there were too many to include in the digital diagram, as it would make it too confusing).

Narrative Formulation. A narrative formulation was developed on the basis of the diagram and shared with the client.

You had a difficult start in life characterized by rejection and loss, which continued throughout your childhood and then into your army career. One understanding is that as a result of these unprocessed traumas, when you are exposed to certain situations, such as being humiliated (e.g., in a work place situation), being rejected (e.g., by a girlfriend), any reminders about armed forces, or driving triggers or mention of the accident, you experience intrusive memories (flashbacks, nightmares) of these traumas—especially the humiliating punishments by your stepfather, the harsh treatment and abuse within the army, the car accident in which your friend was killed, and being discharged from the army. These bring up negative self-beliefs such as: I'm vulnerable/I must not show vulnerability; I'm powerless; I'm unsafe. It's my fault—I ruin everything; I'm unlovable/I'm bad/I don't belong.

As well as making you feel under constant threat (hypervigilant and hyperalert), this may cause you difficulties such as extreme feelings of self-hatred, alcohol and drug abuse, and dissociation to cope with overwhelming feelings and numb out; self-harm to numb and punish yourself, difficult interpersonal dynamics where you feel the need to rescue and then feel rejected and in order to protect yourself you feel the need to act tough and superior to others. You are afraid of current situations in which you might appear weak or might be rejected and you are terrified of aging as it might make you vulnerable and dependent on others.

Although you have all these difficulties, you have strengths and positive experiences: you have a sense of having been loved by your grandparents, you recognize that you are a quick learner and can pick up things quickly in new

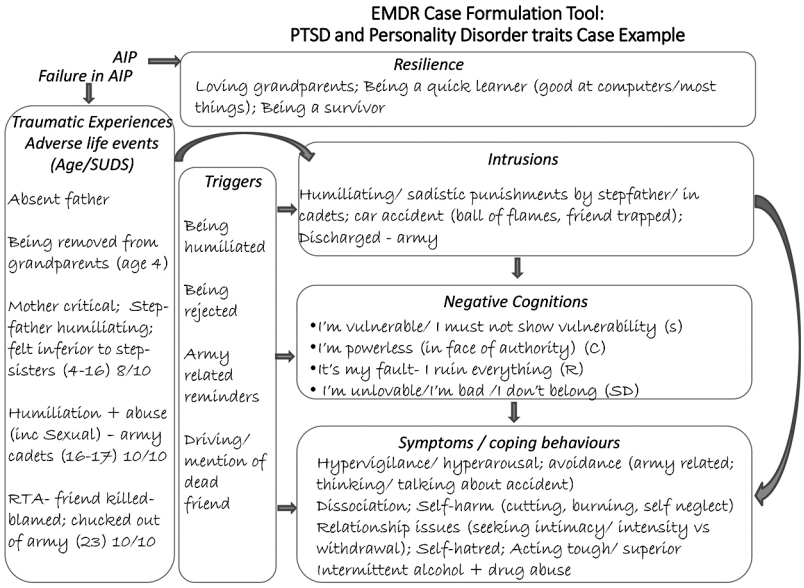

FIGURE 5. EMDR case formulation PTSD and PD traits case example.
Note. EMDR = eye movement desensitization and reprocessing; PD = personality disorder; PTSD = posttraumatic stress disorder.

work places and you see yourself as a survivor—"I've survived worse." All this gives you a lot of resilience.

Discussion

The EMDR Case Formulation Tool was developed over a period of about 2 years, with feedback from local EMDR therapists and clients. As a result of the feedback, the tool is considerably more comprehensive with the addition of a section for positive experiences and resilience as well as for triggers. Through its use in clinical practice and in supervision and case consultation, the tool has helped to share with clients an understanding of their current difficulties and how it relates to past experiences and can help in the creation of a coherent narrative.

One of the strengths of this tool is that it can be used to formulate any clinical presentation where EMDR therapy is being used. Case examples given above illustrate its use with some of these, including a simple PTSD case, a complex PTSD case, and a mixed PTSD and personality disorder presentation. The tool is helpful in each case helping to map the links between the current difficulties and their traumatic origins. For example, in the case example of the client with PTSD and some personality disorder traits (emotionally unstable and narcissistic traits), it seems that is clear the emotionally unstable personality traits to do with traumas of rejection and abandonment and negative beliefs around "I'm unlovable" and "I don't belong." The narcissistic traits are more about humiliating experiences and beliefs such as "I mustn't show vulnerability." The PTSD, on the other hand, is more about lack of safety.

This tool can be used to aid treatment planning in a variety of ways. For example, it can be used to highlight resources that can be installed as well as perhaps a lack of resources, suggesting that more resources may need to be developed and installed. It can highlight issues in current functioning that may need to be addressed directly in the stabilization phase, for example, difficulties sleeping that might respond to some psycho-education, dissociation that may need to be addressed with grounding. The formulation allows for the identification of negative beliefs linked to each memory and underpinning specific current difficulties; as well as current triggers.

Through the linking of negative beliefs and specific symptoms, the function of the symptom can be more clearly understood. For example, the behavior of not going out could be underpinned by the negative belief "I'm in danger," therefore the function is to keep the person safe; or in another case by the belief "I'm out of control" and it being more about keeping others safe. Self-harm might be underpinned by the negative belief "I deserve bad things" or by a belief "I'm overwhelmed/I can't cope" and thus serve different functions. Understanding the function of the symptom/ behavior is extremely helpful in planning treatment. Importantly, the formulation can be used to identify target memories for processing by identifying

memories that are causing the current disturbances and intrusions.

Although the tool has its own diagrammatic formulation that has clinical usefulness, one of the its main strengths is its simple understanding of how to formulate within the AIP model by linking the six key components: unprocessed traumatic experiences, triggers, intrusions, negative cognitions, symptoms, and resilience as it applies to each clinical case. Once clinicians understand the tool, they can draw their own versions, maybe on a large piece of paper, perhaps in different colors, using suggested causative arrows to link the different elements.

It is argued, that the EMDR Case Formulation tool described here is a valuable addition to the existing tools. It is a visual, working tool which provides an easy-to-use approach to case formulation within the AIP model. Other visual ways of conceptualizing cases within EMDR do exist, namely Leeds' case conceptualization (2017), Jarecki's (2014) Seed and Weed Technique and the de Jongh et al. (2010) two method approach. Compared to these other published diagrammatic case conceptualizations, this tool seems both comprehensive and simple to use, therefore it seems to have clinical utility. The Case Formulation Tool includes elements of a timeline but its application is broader than other tools to that effect (e.g., Lombardo, 2012).

It was a real challenge to attempt to come up with a formulation tool that captured the complexities of the AIP model in a way that was simple enough to be used clinically. Inevitably, elements had to be left out; for example, the distinction between causative and contributory factors (Leeds, 2016), which has clinical utility. These elements could nevertheless be incorporated into the formulation and discussed with clients.

An inevitable but major limitation is lack of space on a single page to do justice to each of the elements; for example, to record all the current symptoms or all the unprocessed traumatic memories. This becomes more of an issue with increasing complexity. For clients with multiple traumas and very complex current presentations, a diagram on a single page may not be enough and multiple formulations (organized for example around clusters of traumas) might be helpful so that the formulation is detailed enough to be clinically helpful. In my experience, clients found this very helpful and we used the multiple formulations with ease, using in the moment the one that was most relevant. Connections can be made across the different diagrams and recurrent patterns identified across clusters, memories, or symptoms.

The next stage is for the EMDR Case Formulation Tool to be evaluated in a systematic way, across clinical settings, and populations, so that its clinical usefulness can be ascertained and perhaps revisions made. In addition, the EMDR Case Formulation Tool, as it stands, is not ideal to use with children, young people, or people with learning disabilities, and adaptations would be needed. This is a piece of work that is being considered in collaboration with child and learning disabilities specialist EMDR therapists, to be published in the future.

Conclusions

In many ways, nothing in the EMDR Case Formulation tool is new, which is as it should be given that it is a way of formulating EMDR clients within the AIP model. But what is new is the diagrammatic representation of the AIP model and the way that the formulation of the client's difficulties are mapped onto the AIP model through the six key elements. This enables looking at the whole of the clients' difficulties, making suggested causal links and connections. The tool is also very simple at its core, which means that it is robust and easy to apply.

This tool is just the beginning, and hopefully other adaptations will arise that may capture even more aspects of the AIP model or the complexities of the presentations we see in clinical settings. It will be interesting in the future to see published worked formulations using this tool with clients with OCD, chronic pain, or a myriad of other presentations. The goal is that this tool will encourage the widespread use of formulation within EMDR therapy.

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