The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI)

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Early EMDR Intervention (EEI)

The question of how early to intervene with EMDR in the face of natural and man-made disasters has been an important part of the dialogue of those working in this field. As a result of the human beings suffering in the wake of these catastrophes, a number of ideas have ensued and new ways to work with the pain and anguish have been explored. Whereas the majority of people who experience a significant trauma will recover spontaneously, there is often prolonged suffering and about one-third may be left with enduring distressing clinical or subclinical symptoms of posttraumatic stress disorder (PTSD) and other psychiatric disorders (National Institute for Clinical Excellence [NICE], 2005).

Early EMDR intervention (EEI), before consolidation of the memory has taken place, may reduce associative connections to past traumas, preventing the accumulation of traumatic memories. It may also enhance adaptive associations, promoting adaptive integration reflected in self-affirmation, coping, resilience, and other measures of "post-traumatic growth." Therefore, early EMDR intervention should be considered following a significant trauma. How and when to intervene with EEI most effectively and whether it can thereby reduce the incidence of PTSD and other disorders that can follow trauma are among the challenges that need to be studied empirically.

Informed by the work of Francine Shapiro, Roger Solomon, and all of the friends and colleagues in the field who have contributed to the evolution of their thinking and practice and following clinical and empirical experience with early EMDR intervention in the wake of the 2006 Lebanon war, the authors have observed that the existing EEI protocols appear to focus on certain aspects or parts of the traumatic episode along an approximate time line continuum following a trauma, in accordance with the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013). They concluded that the unfinished processing of recent traumatic events may require a broader approach than existing early EMDR intervention (EEI) protocols provided.

Looking at the existing protocols, Shapiro and Laub (2008) suggest that the earliest interventions (e.g., emergency room protocols) that use elements of EMDR, such as Bilateral Stimulation (BLS), are primarily used for calming and stabilization for Acute Stress Response (ASR). The EMD Protocol is most effectively used for processing intrusive sensorimotor fragments. The protocol for Recent Traumatic Events (RTE) is used for processing an unconsolidated discrete event and the Standard EMDR Protocol is used to process memories that are already consolidated in a theme cluster. However, they suggest that the original traumatic incident and its aftermath may be conceived more like an ongoing *trauma continuum* while the experiences have not yet been consolidated. They propose a new protocol called the Recent-Traumatic Episode Protocol (R-TEP), which incorporates and

extends the existing EEI protocols by providing a new comprehensive, integrative protocol. The R-TEP thus bridges the gaps left by previous protocols and facilitates a transition from the EMD and RE protocols to the Standard EMDR Protocol.

The R-TEP takes the wisdom of the Standard EMDR Protocol (Shapiro, 1995, 2001), and applies it in an adapted form for recent events to provide a comprehensive approach to Early EMDR Intervention. It is a protocol that adapts the EMD and the Recent Event Protocols within a newly conceived extended time perspective, termed here the "Traumatic Episode." The Traumatic Episode (or T-Episode) comprises a number of targets of disturbing fragments and experiences (images, sensations, feelings, and thoughts) in the trauma continuum, from the original incident until the present, which need to be processed.

New theoretical conceptualizations of the process of memory consolidation, relating to Francine Shapiro's Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001), guided the development of the R-TEP. It is suggested that the stages of this process proceed hierarchically according to part/whole relations aiming toward adaptive integration (see Figure 12.1). This integrative sequence is of a broadening focus from the intrusive image/sensation fragment to the event, to the episode that includes many events, to the theme, and to the identity that is comprised of clusters of themes. When a part (such as an intrusive fragment) is stuck (blocked/dissociated or locked/re-experienced), the AIP system is disrupted and cannot move toward the next whole, and thus fails to reach integration. Information is transmitted at increasing levels of complexity, from the sensorimotor (sensory and somatic) to the experiential (sensorimotor and emotional) and to the meaning (sensorimotor, emotional, and cognitive) levels, perhaps matching the evolution of the brain. It is assumed that the AIP system moves toward integration dialectically via associative connections between the various opposites of the traumatic memory networks and the adaptive ones (horizontal dialectical movement) going through part/whole integrative sequences (vertical dialectical movement) (Laub & Weiner, 2011).

The R-TEP employs an adapted eight–phase structure, with some modifications for application to early EMDR intervention. These modifications are based on the fragmented nature of the memory, on the need for containment and safety, and the wider T-Episode time frame. The T-Episode is conceived as a continuum from the original incident to the present and anticipated future concerns.

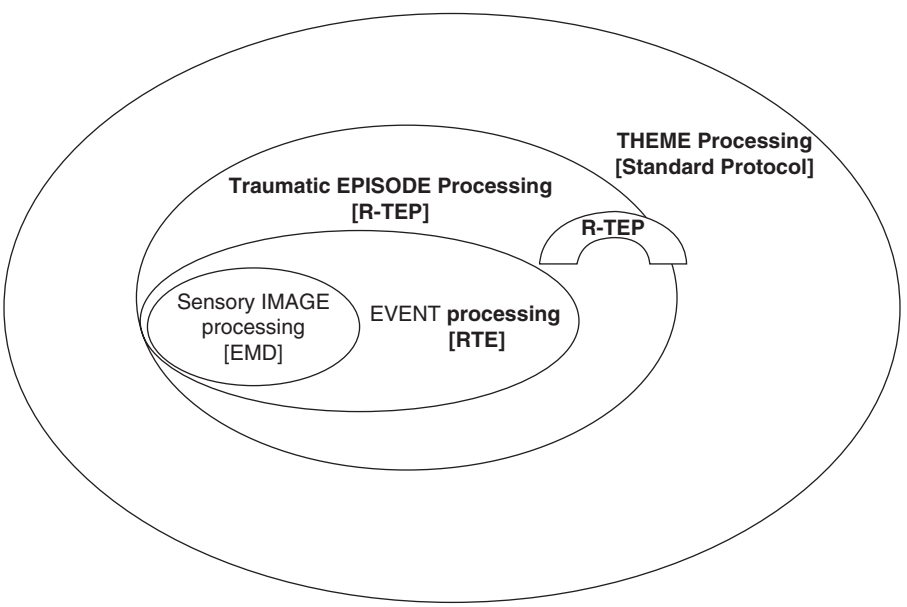

Figure 12.1 R-TEP (Recent-Traumatic Episode Protocol). Part/whole integrative sequence of the memory consolidation process after recent trauma—a bridge from episode to theme processing in early (EMDR) interventions (EEI) (Shapiro & Laub, 2008).

Main Issues in Early EMDR Intervention (EEI)

Clinical experience indicates that EMDR can be beneficial for alleviating excessive distress and complications in the weeks and months following critical events. However, there seems to be uncertainty and inconsistency among many clinicians about which protocols to use for Early EMDR Intervention and how and when to use them. Consequently, there is a need for a comprehensive model and set of guidelines in the EMDR practitioner's toolbox to assist in approaching the prospect of EEI with more confidence and to generate research.

Issues to consider when working with EEI:

1. *Memory:* In recent trauma the nature of the memory is fragmented and not consolidated; it requires a different protocol.
2. *When to Intervene:* When there is distress, particularly when it is clinically significant, when to intervene is straightforward. However, when symptoms are subclinical, the question to ask is, "Is prevention to be considered?" Reference is made to the literature on delayed-onset and sensitization (Andrews, Brewin, Philpott, & Stewart, 2007; McFarlane, 2010).
3. *Therapeutic Situation:* The nature of the situation for client and therapist is that there is an atmosphere of emergency or urgency that often results in high arousal or distress and sometimes avoidance; this requires a special attention to containment and safety.
4. *Therapy Contract:* The nature of the therapy contract may be unclear, and as a result professional and ethical standards may be compromised; this requires good practice guidelines. The R-TEP attempts to address these issues within the protocol as a comprehensive approach to EEI.

The Recent-Traumatic Episode Protocol Features

Main Features of R-TEP

1. A comprehensive approach to EEI: The eight phases.
2. An integrative approach to EEI: Incorporates adaptations of the EMD and RE protocols.
3. The Traumatic-Episode (T-Episode): This is a newly conceived trauma continuum time frame.
4. The Google-Search (G-Search): This is a procedure for scanning and identifying targets of disturbance or Point of Disturbance (PoD) within the T-Episode.
5. "Telescopic Processing": Suggests three optional strategies for the processing in Phase 4 (Desensitization) for a contained intervention with varying boundaries for the chains of associations. Advocating a current trauma focus, the EMD strategy provides a narrow focus on the disturbing fragment; the EMDr strategy enables a broader focus on the current trauma episode; or (only if necessary and with client consent), the EMDR strategy that relates to the whole of life experiences.
6. Special attention to containment and safety.
7. Maintaining standards of good practice.
8. Theoretical underpinning.

Adapted Eight Phases of the R-TEP

This novel application of the eight–phase framework for EEI provides a structure that fosters safety and maintains professional standards of good practice even in recent event situations where they risk being compromised. The eight phases follow the Standard EMDR Protocol, but they are divided into three groupings to emphasize the specific features of the R-TEP:

A. Episode history taking and preparation (often neglected in EEI)
   1. Phase 1: History-Taking/Intake
      To assess readiness for EEI.

2. Phase 2: Preparation
   To attend to safety, containment and gaining some self-stabilization and control

B. Point of Disturbance (PoD) Level of Processing
   To identify, assess, and process disturbing targets.
   1. Traumatic-Episode narrative with continuous Bilateral Stimulation (BLS)
      To tell the story of the traumatic episode out loud with BLS
   2. "Episode Google Search"
      To identify Points of Disturbance relating to the T-Episode from the original incident until today, including all the related events and disturbances.
   3. Assessment of each PoD in turn that becomes the target fragment, using as much of the Standard EMDR Protocol assessment as appropriate (use clinical judgment)
   d. "Telescopic Processing"
      The term "Telescopic Processing" is used to reflect the three optional strategies for Phase 4 Desensitization: (EMD < > EMDr …. EMDR) following the memory consolidation process after recent trauma.

C. Episode Level—the Trauma-Episode is related to as a whole
   1. Check Episode Subjective Unit of Disturbance (SUD)
   2. Episode Level Phase 5: Installation of Episode Positive Cognition (PC)
   3. Episode Level Phase 6: Episode Body Scan
   4. Phase 7: Closure of the Episode
   5. Phase 8: Follow Up

The Google Search (G-Search)

The Google Search (G-Search) is a metaphor for a scanning procedure to identify targets of disturbance within the T-Episode. It identifies Points of Disturbance targets non-sequentially, in a natural associative way. Each target is identified from the entire episode and processed (usually about three or four targets in two to four sessions, optionally on consecutive days), to reach adaptive resolution. When there are no more targets identified at this Points of Disturbance level, go to the Episode level of the entire Trauma-Episode, which includes the Episode PC and Installation, Body Scan, and Closure; this is usually quite a short procedure.

The (recent) past traumatic incident influences our sense of safety and control in the present as well as our future expectations. Therefore, concerns about the future arising during the G-Search may also be important targets for processing.

Special Attention to Containment and Safety

In addition to the containment and safety provided by the adapted eight phase framework and the stabilization and resources exercise in the Preparation Phase, there are some other measures.

Episode Narrative

During Phases 1 and 2, the client is deliberately not asked to recount the details of the trauma yet, except in general terms, so as to avoid prematurely triggering abreaction and possible re-traumatization before containment and safety measures are in place and treatment processing can begin. The Trauma-Episode Narrative is carried out adding BLS during the telling of the story with an optional distancing technique. This appears to increase the sense of safety because of the presumed grounding and de-arousal effects of the BLS.

Telescopic Processing: A Three Strategies Approach (EMD <—> EMDr With Optional EMDR)

The possibility of using three strategies with different boundaries for chains of associations can provide contained processing. The narrow focused EMD processing allows a brief and contained processing of intrusive fragments that may block the AIP system. The boundaries

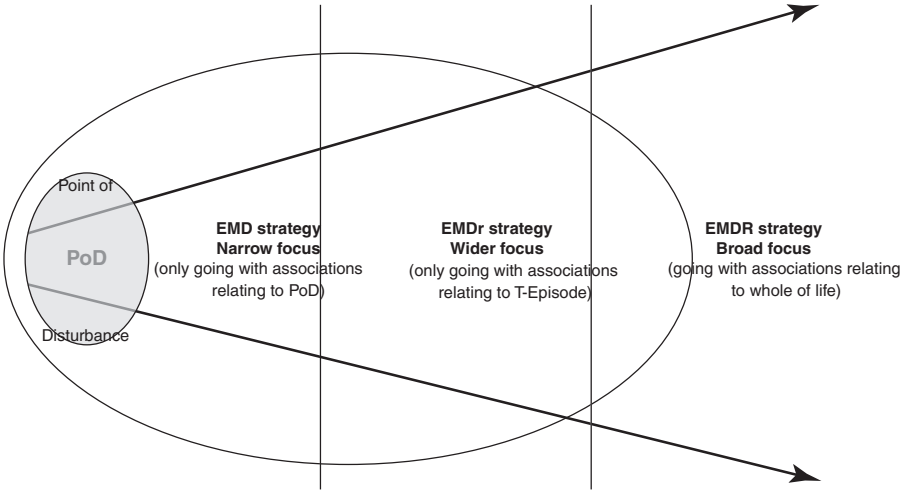

Figure 12.2 R-TEP "Telescopic Processing." Three optional strategies of a broadening focus: EMD, EMDr, or EMDR. (From Shapiro & Laub, 2011.)

in EMDr processing with associations predominantly relating to the current trauma episode discourages opening past channels that may overload, while acknowledging their possible relevance; thus, differentiation between past and present is encouraged, thereby allowing a more contained processing.

Guidelines for Maintaining Standards of Good Practice With R-TEP

In the unusual circumstances of EEI, there are a number of risks that should be noted to ensure optimal EMDR therapy practice. There are various opinions about early psychological intervention and there is no intervention yet which evidence-based practice has endorsed for routine intervention (Roberts, Kitchiner, Kenardy, & Bisson, 2009, for the Cochrane review). There are legitimate concerns about premature intervention, fear of causing harm, short cuts, and coping with affect containment.

Prior History. The way in which the clinician intervenes in EEI needs to be considered. In general, the clinician will encounter normal people who have been exposed to abnormal situations. However some of them will have previous histories of pathology, dysfunction, or trauma. Specifically, care should be taken to avoid common pitfalls such as: excessive shortcuts in Phases 1 (insufficient history, intake, ego strength assessment) and 2 (insufficient rapport and preparation), as well as opening other clinical issues when this is not part of the therapy contract (in EMDR you know where you start but not where you may go).

Traumatic Episode. When possible, give priority to focusing on the traumatic episode and its concomitants, and only go into other clinical issues that arise if this is not sufficient to promote adaptive processing. While we need to be flexible in these circumstances, we also need to bear in mind our professional boundaries and standards when working with recent trauma.

Timing of Intervention. The question of when to intervene is still an open question and there are various opinions of when to intervene.

Guidelines for When to Intervene

In General. When Psychological First Aid is not sufficient, when there is excessive suffering and persistent disturbing symptoms, especially intrusive images and sleep disturbance, when high risk is evaluated, and/or when preventive action is possible.

Hours After Trauma. In addition to Psychological First Aid, consider first using the Emergency Response Procedure (ERP) for stabilizing and calming, an alternative to medication (see Chapter 9).

Days After Trauma. Use R-TEP with a likely focus on brief EMD for intrusions and sleep disturbance.

Weeks and Months After Trauma. Use R-TEP with focus on EMDr for treatment of traumatic stress and/or prevention of accumulation of trauma memories and sensitization (see McFarlane, 2010).

The R-TEP proposes a current trauma episode focused therapy contract. However, the Standard EMDR Protocol is always available for use when the EMDr and EMD strategies are not sufficient for adaptively processing the current trauma episode and previous trauma or blocking beliefs need to be considered. This requires client consent.

The R-TEP, therefore, embodies a set of guidelines, with built-in safeguards for checking one's work and maintaining standards of good practice in line with the Standard EMDR Protocol.

The Recent-Traumatic Episode Protocol (R-TEP) Notes

2013 Update: Note the changes in the guidelines for Telescopic Processing Phase 4 Desensitization strategies.*

Phase 1: Client History/Intake

Obtain as much client history and information as possible in the circumstances to screen for previous pathology. Administer the Impact of Events Scale (IES-R) when possible, to obtain a baseline measure prior to intervention as part of the assessment and again post intervention to assess effectiveness. Then, estimate Severity, Motivation, and Strengths (SMS) ratings on a 5–point scale (1 = low to 5 = high) in order to decide whether it is appropriate to proceed with EMDR processing with the client at this time. Minimum strengths and motivation ratings of 3 are advocated to proceed when the severity is high.

A summary of SMS ratings based on all information obtained and clinical impression is listed.

S	= Severity	(low) 1	2	3	4	5 (high)
M	= Motivation	(low) 1	2	3	4	5 (high)
S	= Strengths	(low) 1	2	3	4	5 (high)

Phase 2: Preparation

In early EMDR intervention, clients are likely to be easily flooded with states of high arousal and distress. Therefore, Phase 2 Preparation is particularly important for establishing sufficient safety, containment, and some sense of control to enable EMDR processing.

In all cases, start with stabilization and resource exercises for calming and enhancing control such as: The Four Elements for Stress Management (see Chapter 8), Safe Place (E. Shapiro, 2009a, pp. 67–69), and Resource Connection (Laub, 2001, 2009, pp. 93–99). Write down the exercises or scripts used for each of these.

During Phases 1 and 2, the client is deliberately not asked to recount the details of the trauma yet, except in general terms, so as to avoid triggering abreaction and possible re-traumatization before containment and safety measures are in place and treatment processing can begin.

Point of Disturbance (PoD) Level of Processing (Phases 3, 4, 5, and 7)

These phases include assessment and processing of the targets identified in the traumatic episode, from the original incident until today, including disturbing thoughts about the future.

The goal of episode processing is to integrate the intrusive fragments and other disturbing experiences of the Trauma Episode into an adaptive episode that is finally integrated into the autobiographical story of the individual.

1. *Episode Narrative With Bilateral Stimulation (BLS)*
   In the Episode Narrative, the client tells the story of the traumatic episode out loud with BLS, which helps to ground and contain affect. It is the first time that the client tells the traumatic story in a sequential and detailed way in the presence of an empathic witnessing therapist. It seems that this procedure entails an initial processing, though more verbal and conscious than Telescopic Processing, which brings about an initial sense of integration. Using a distancing metaphor, such as a TV screen, gives additional containment if needed.
2. *Episode "Google Search" (or G–Search) With BLS*

   Note: For clients who may not understand the Google Search metaphor, just say, "Scan."
3. For the assessment of each PoD in turn, use as much of the Standard EMDR Protocol assessment as appropriate (when there is high arousal and/or the PoD is an activating intrusion, flexibility is advised and a partial assessment may be conducted).
4. *Telescopic Processing*
   Provides boundaries for focused contained processing: the EMD strategy for a narrow PoD focus and the EMDr strategy for a broader current trauma episode focus. The EMDR strategy of the Standard EMDR Protocol is used if the other two strategies were not sufficient to reach adaptive resolution.
   - *__EMDr strategy:__ This is the main strategy of Telescopic Processing. In this strategy the associative span relates *to the current traumatic episode.* If an association comes up—which is not related to the traumatic episode—it is acknowledged but the client is asked to re-focus by going Back To Target (BTT) to the PoD and checking the SUD.
   - *__EMD strategy:__ Narrow focused processing limiting the range of associations to those related only to the PoD. This is a brief strategy, particularly effective with intrusive image/sensation fragments. If the association is not directly related to the PoD, the client is asked gently to re-focus by going BTT and checking the SUD frequently.
     The EMD strategy is suggested in the following situations:
     a. When the target/PoD is an intrusive element fragment (frequently recurring disturbing image, sensation, thought, feeling). However, if the SUD is not reducing significantly after about six sets, then expand naturally into the EMDr strategy.
     b. When there is still an intrusive/painful fragment that blocks the AIP system, or when the SUD level is not reducing with the EMDr strategy, consider narrowing to an EMD strategy, in addition to Interweaves Procedure, which can be attempted to get the processing moving
   - **EMDr strategy:** This is the widest focus. It is only used, if necessary, to include the whole span of life with no limitation of associations, according to the Standard EMDR Protocol. It requires the client's consent, as the initial contract is the current trauma focus. This step is optional and rare.

The Recent Traumatic Episode Protocol Script

Explanation of R-TEP

This is the introduction to the R-TEP given to the client:

> Say, *"This EMDR protocol is especially suited for early intervention. Its aim is to help your natural processing system process the disturbing fragments of the traumatic episode so that you can restore your balance. Let whatever comes to mind come up. Sometimes, I will ask you to go back to a certain part of the memory, and sometimes not. At other times, we might note something that we could come back to later, if we choose, then we will refocus on the current traumatic*

episode. It is like zooming in, or zooming out, which can help you focus on, observe, and process your memories and experiences, so that the past and present are not confused, and you can begin feeling calmer, safer, and more in control."

Episode Narrative Script

In the Episode narrative, the client tells the story of the traumatic incident out loud with EMDR.

Say, *"Do you feel* (relatively) *comfortable and safe here now in this room?"*

If the answer is no, then more preparation and stabilization is needed first.

Say, *"I am going to ask you to view the whole T–Episode, beginning a few minutes before it started until today. Feel your feet on the ground, the safety of this room, and tell the story out loud."*

If this is too close for the client, suggest the following:

Say, *"I am going to ask you to view the whole T–Episode, beginning a few minutes before it started until today. Feel your feet on the ground, the safety of this room and tell the story out loud and watch the whole episode as on TV. Imagine that you are watching the episode on a screen with a remote control that can make the screen smaller, farther away, lower the volume, or even pause it."*

Use continuous BLS during the Episode narrative.

Episode Google Search Script

In the Google Search Script, the client searches for anything disturbing, and in no particular order.

Say, *"Now, without talking out loud this time, return to scan the whole episode—like a Google Search in the computer—for anything that is disturbing, and in no particular order. Just notice what comes up as you search the whole episode from the original event until today and stop at what is disturbing you."*

Use continuous BLS during the G–Search.

Assess (Phase 3) the target of the identified PoD (intrusive fragment or more complex experience). Target and process each PoD (intrusive fragments and other experiences of the events within the episode). For Phase 3, use as much of the Standard EMDR Protocol assessment as appropriate such as NC, PC, VoC, Emotion, SUD, and Body Sensation. During the Telescopic Processing (Phase 4: Desensitization), use mostly the EMDr Strategy. If the PoD

is an intrusive fragment use the EMD strategy. During EMDr, if processing is stuck because of an intrusive fragment, consider using the EMD Strategy.

Phase 3: Assessment

Target

Say, *"Describe the disturbance."*

_____

_____

If the PoD is not an image, access a picture associated with it.

Say, *"When you focus on the* _____ *(*state the PoD*), what picture comes in mind?"*

_____

_____

Negative Cognition (NC)

Say, *"What negative words go with that* _____ (state the PoD) *about yourself now?"*

_____

_____

A negative cognition related to the situation and not to the self is accepted. If there is high arousal or difficulty in rapidly finding an NC, suggest a suitable NC. Clients usually speak about physical survival categories of safety or control in these types of situations, such as, *"I'm in danger," "I am helpless," and "It shouldn't happen."*

Positive Cognition (PC)

Say, *"When you bring up that* _____ (state PoD), *how would you like to think about it, or about yourself?"*

_____

_____

If it is difficult to find a PC, while the level of disturbance is high, offer a tentative PC that is appropriate to the NC.

Say, *"Would you like to believe that 'It happened and it's over,' 'I survived,' 'I am safe now from THAT event,' and 'I can cope'? Is that what you would like to believe or is there something else you prefer?"*

_____

_____

Validity of Cognition (VoC)

You can skip the VoC, if it is not appropriate to ask at this stage.

Say, *"On a scale of 1 to 7, where 1 is completely false and 7 is completely true, how true do these words feel to you now?"*

1 2 3 4 5 6 7
(completely false) (completely true)

Emotions

Say, *"When you bring up that* _____ (state PoD) *and those words* _____ (state the negative cognition), *what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance (SUD)

Say, *"On a scale of 0 to 10, where 0 is bringing up the PoD and staying relatively calm and 10 is the highest disturbance you can imagine, how disturbing does the image feel to you now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it in your body?"*

Phase 4: Telescopic Processing (Desensitization)

When working with R-TEP in the Telescopic Processing/Desensitization Phase, follow these guidelines:

1. Begin (usually) with the main EMDr strategy by focusing on chains of associations relating directly to the current Traumatic Episode.
2. When an intrusive image/sensation/emotion or thought is identified consider using the narrow-focused EMD strategy: short chains of associations relating only to the disturbing fragment (PoD).
3. Only if the first two strategies are not sufficient then consider employing the Standard EMDR Protocol with free associations related to the whole of life experiences, as in unlimited chains of associations. This is a clinical choice point that requires client consent.

EMDr Strategy for R-TEP Script

EMDr is the main strategy of the Telescopic Processing.

1. If the association is about the T–Episode:
   Say, *"Go with that."*

Continue with BLS and chains of associations as long as the association is related to the episode.

2. If the association is not about the T–Episode:

Say, "We can note that, but as we have agreed to focus on the episode, I will ask you now to go back to the original disturbance _____ (state the PoD).*What do you get now?"*

_____

_____

Say, *"On a scale of 0 to 10, where 0 is bringing up the PoD and staying relatively calm and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Continue the processing in this way until the SUD level drops to an ecological level or the target (PoD) can be viewed calmly. Then, proceed to the Installation Phase (see the Standard EMDR Protocol Script below).

Choice Point: If the SUD level still is not reducing or processing gets stuck, do another Google Search for another PoD. If processing is stuck, then, using your clinical judgment and with the client's consent, consider using the Standard EMDR Protocol.

Phase 5: Installation of the PoD

During assessment, a tentative PC was offered. An opportunity is given to find a more suitable PC now that the SUD has reduced.

Say, *"How does* _____ (repeat the PC) *sound?"*

Say, *"Do the words* _____ (state the PC) *still fit, or is there another positive statement that you feel would be more suitable?"*

If the client accepts the original positive cognition, the clinician should ask for a VoC rating to see if it has improved.

Validity of Cognition (VoC)

Say, *"As you think of the* _____ (state the original disturbance/PoD) *and those words* _____ (repeat the selected PC), *how true do they feel, from 1* (completely false) *to 7* (completely true)*?"*

1 2 3 4 5 6 7
(completely false) (completely true)

Say, *"Go with that."*

Do BLS. Then say the following:

Say, *"Think of the* _____ (state the PoD), *and hold it together with the words* _____ (repeat the PC)*."*

Continue installation, with brief BLS, as long as the VoC strengthens.

Note: There is no Phase 6: Body Scan at this PoD Level of Processing as this is just one target of several.

Continue with the Episode G–Search, as before, to check if there are any other PoDs left and process similarly with Telescopic Processing.

Say, *"Now, again, without talking out loud, return to scan the whole episode, like a Google Search on the computer, for anything else that is disturbing you, in no particular order. Just notice what comes up as you search the whole episode from the original event until today and stop at what is still disturbing you and we will use it as a target for processing."*

Use continuous BLS during the G–Search.

Process any additional identified targets (PoDs) using Telescopic Processing. Repeat until there are no more targets.

When an intrusive image/sensation/emotion or thought is identified, consider using the narrow-focused EMD strategy.

EMD Strategy for R-TEP Script (Adapted From the EMD Protocol, Shapiro, 1995)

The EMD strategy limits associations. If associations relate directly to the PoD, the processing is continued. If associations depart from the PoD, then there is a return to Target (the PoD), and the SUD level is checked. A distancing metaphor can be suggested to help with high arousal if needed. It is usually a brief procedure, so if the SUD is not reducing after about six sets, "Zoom Out" smoothly to a wider EMDr strategy.

Say, *"I'd like you to bring up that* _____ (state the PoD), *those negative words* _____ (state the negative cognition), *and notice where you are feeling it in your body. Go with that."*

Ask the client to indicate when he wants to rest and stop the set.
Do a set of BLS. Sets could be short if client is in a high arousal.

After the set, say the following:

Say, *"Take a deep breath. What do you get now?"*

If the association is within the boundaries of the PoD continue.

Say, *"Go on."*

If the association departs from the PoD, go back to target (PoD)

Say, *"I would like to ask you to focus again on the* _____ *(*state the PoD*) so you may digest it. Do you notice any change?"*

Say, *"On a scale of 0 to 10, where 0 is bringing up the PoD and staying relatively calm and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Do another set of BLS.

Say, *"What do you get now?"*

If the association is within the boundaries of the PoD continue.

Say, *"Go with that."*

If the association departs from the PoD, go back to target (PoD).

Say, *"Let's go back again to the ____ (*state the PoD*). On a scale of 0 to 10, where 0 is accessing the PoD and staying relatively calm and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Continue for about 6 to 10 sets until the SUD level reduces to ecological validity or when the original target can be viewed relatively calmly. Then proceed to installation of the PoD.

If there is no change after about six sets, zoom out to EMDr strategy.

Note: If the SUD level is not reducing after about six sets, proceed without interrupting the flow (and without a new assessment), with a transition to the EMDr strategy (see above), which widens the focus of associations to the current traumatic episode.

Future Targets

Concerns about the future such as, "*What if it happens again*?," a disrupted sense of personal safety, and challenges to the client's basic assumptions may arise during the G–Search. These future targets are processed in the same way as other targets. This may be helpful for strengthening resilience.

Since the T–Episode is comprised of several targets, the G–Search can be used over several sessions.

Ensure a strong closure at the end of each session using the Four Elements Exercise and/or a Resource Connection.

Episode Level

Checking the Episode-SUD (E-SUD)

When no more targets emerge with G–Search, check the SUD level for the entire T–Episode.

Say, *"When you think of the entire episode now, how disturbing is it to you on a scale of 0 to 10, where 0 is staying relatively calm and 10 is the highest disturbance you can imagine?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

When the SUD is ecological, proceed to installation of the Episode PC.

Phase 5: Installation of Episode Positive Cognition (E-PC)

Obtain a PC for the *entire* episode.

Say, *"When you think about the entire episode, how would you like to think about it now? What have you learned from it?"*

_____

_____

_____

Obtain a PC for the *entire* episode. Check the VoC.

Say, *"As you think of the entire episode again, how do the words* _____ (state the E–PC) *feel, from 1* (completely false) *to 7* (completely true)*?"*

1 2 3 4 5 6 7
(completely false) (completely true)

Say, *"Hold them together, the entire episode and these words* _____ (repeat the E–PC)*."*

Install with sets of BLS and check the VoC.

Say, *"As you think of the entire episode again, how do the words* _____ (state the E–PC) *feel, from 1* (completely false) *to 7* (completely true)*?"*

1 2 3 4 5 6 7
(completely false) (completely true)

Continue installation until it no longer changes and the VoC is 6 or 7. If the VoC is less than 7, say the following:

Say, *"What prevents this from being a 6 or 7?"*

Do BLS.

Say, *"Go with that."*

Phase 6: Episode-Body Scan (This Is the Only Time the Body Scan Is Requested)

Say, *"When you think of the entire episode and your positive cognition* _____ (state E–PC), *notice any body sensations. Go with that."*

Use sets of BLS as in the Standard EMDR Protocol.

Phase 7: Closure of the Episode

At this stage, after all the PoDs have been processed and the Episode PC has been installed, a supportive soft closure is suggested (e.g., a closing resource).

Phase 8: Follow Up

Check the Episode SUD Level.

Say, *"On a scale of 0 to 10, where 0 is bringing up the entire episode and staying calm with no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the entire episode feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

If the SUD does not equal 0 or does not seem ecological, use G–Search to identify any residual targets that may require additional processing.

Say, *"Now, again, without talking out loud, return to scan the whole episode, like a Google Search on the computer, for anything else that is disturbing you, in no particular order. Just notice what comes up as you search the whole episode from the original event until today, and stop at what is still disturbing you, and we will use it as a target for EMDR processing."*

Use continuous BLS during the G–Search.

Administer the Impact of Events Scale-R (IES-R) again.
Check the SUD and use the IES-R once again after 3 months.

Comments about the process:

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