HANDOUT #1

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

Overview & protocol instructions

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EMDR R-TEP is a comprehensive current trauma focused protocol for EEI that incorporates and extends the existing EMD and Recent Event protocols together with additional measures for containment and safety. The EMDR R-TEP usually requires 2-4 sessions, which can optionally be conducted on successive days.

GLOSSARY of KEY TERMS

1- Traumatic Episode (T-Episode)

The original traumatic incident together with its aftermath is viewed as an on-going trauma continuum while the experiences are not yet adaptively processed. The T-Episode comprises multiple targets of disturbance. These Target fragments are referred to as **Points of Disturbance (PoDs)**, from the original incident until today.

2- Episode Narrative + continuous BLS (Bi-Lateral Stimulation)

The Episode Narrative is telling the story of the traumatic episode out loud with continuous BLS which helps to ground and contain affect. This initial processing begins to integrate the gaps of the fragmented traumatic story. In phases I & II recounting the details of the trauma is discouraged to avoid premature activation
Option: Using a distancing metaphor, e.g. T.V screen, gives additional containment if needed.

3- Google Search (G-Search) or Scan

The G-Search is a mechanism to identify the various Points of Disturbance (PoD) by non- sequential scanning of the T-Episode, without talking, together with BLS.

4- Focused Processing[1]: A two strategies approach EMD <→EMDr

EMD strategy: Narrow focused processing of the PoD by limiting the range of associations to the PoD . This is a brief strategy, particularly effective with intrusive image/sensation fragments.

EMDr[2] strategy: Wider focused processing of the PoD, by going with the AIP chains of associations relating to the T-Episode. This is usually the main strategy.

[1] Previously called Telescopic Processing
[2] Term after Roy Kiessling.

Overview: Adapted 8 Phases

Phase I: HISTORY /INTAKE, brief history taking, evaluate readiness

Phase II: PREPARATION, attention to safety & containment

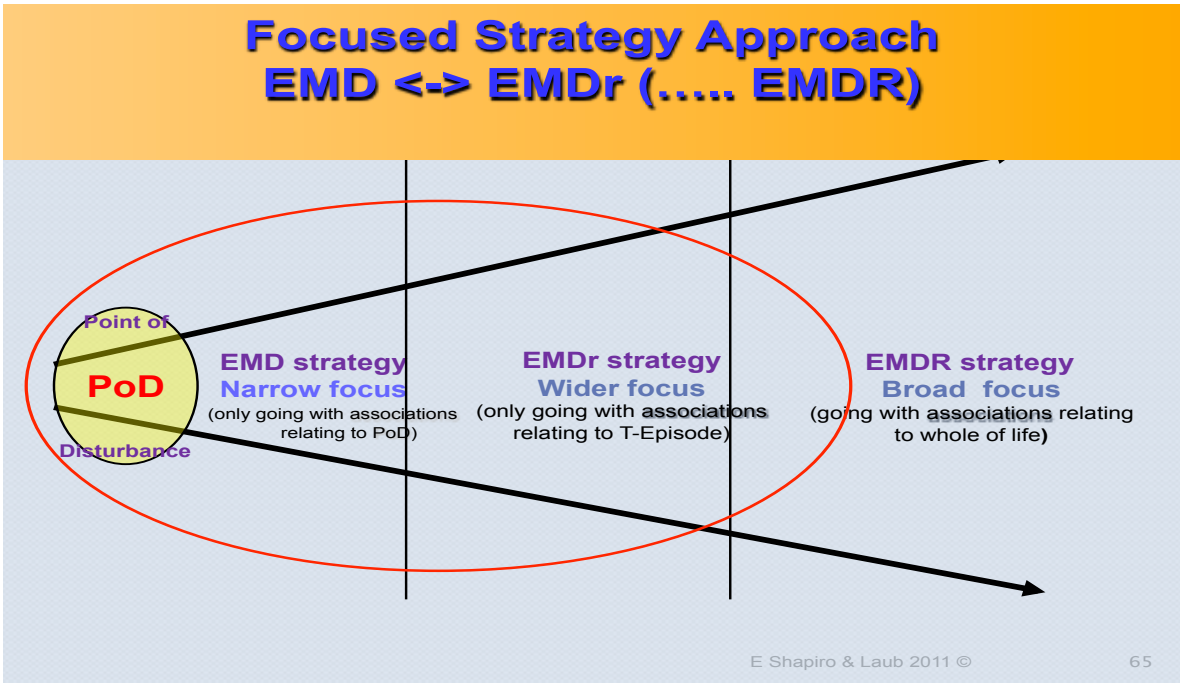
Points of Disturbance (PoD) level:

Identification, assessment and Focused Processing of target fragments (PoDs) within the Traumatic Episode

1. **Traumatic Episode Narrative + continuous BLS** (Bi-Lateral Stimulation) -telling the story of the traumatic episode out loud with BLS.
2. **Episode Google- Search + BLS** (identifying **Points of Disturbance (PoD)** relating to the T-Episode from the original incident until today)
3. **Assessment (phase III) of each PoD (Point of Disturbance)** identified from G-Search
4. **Focused Processing (Desensitization- phase IV)**:
   2 strategies approach (EMD <→EMDr)
5. **Installation (phase V) if SUD is ecological**
   (no BODY SCAN (phase VI) yet)
6. **Repeat steps 2-5 to identify & process remaining PoDs, until none found**
7. **A strong Closure (phase VII) at end of each session**

Episode level

Check Episode SUD
INSTALLATION of Episode PC (phase V)
Episode BODY SCAN (phase VI)
CLOSURE of Episode (VII)
FOLLOW – UP (VIII)


Focused Strategy Approach
EMD <-> EMDr (….. EMDR)
Point of
PoD
Disturbance
EMD strategy
Narrow focus
(only going with associations relating to PoD)
EMDr strategy
Wider focus
(only going with associations relating to T-Episode)
EMDR strategy
Broad focus
(going with associations relating to whole of life)
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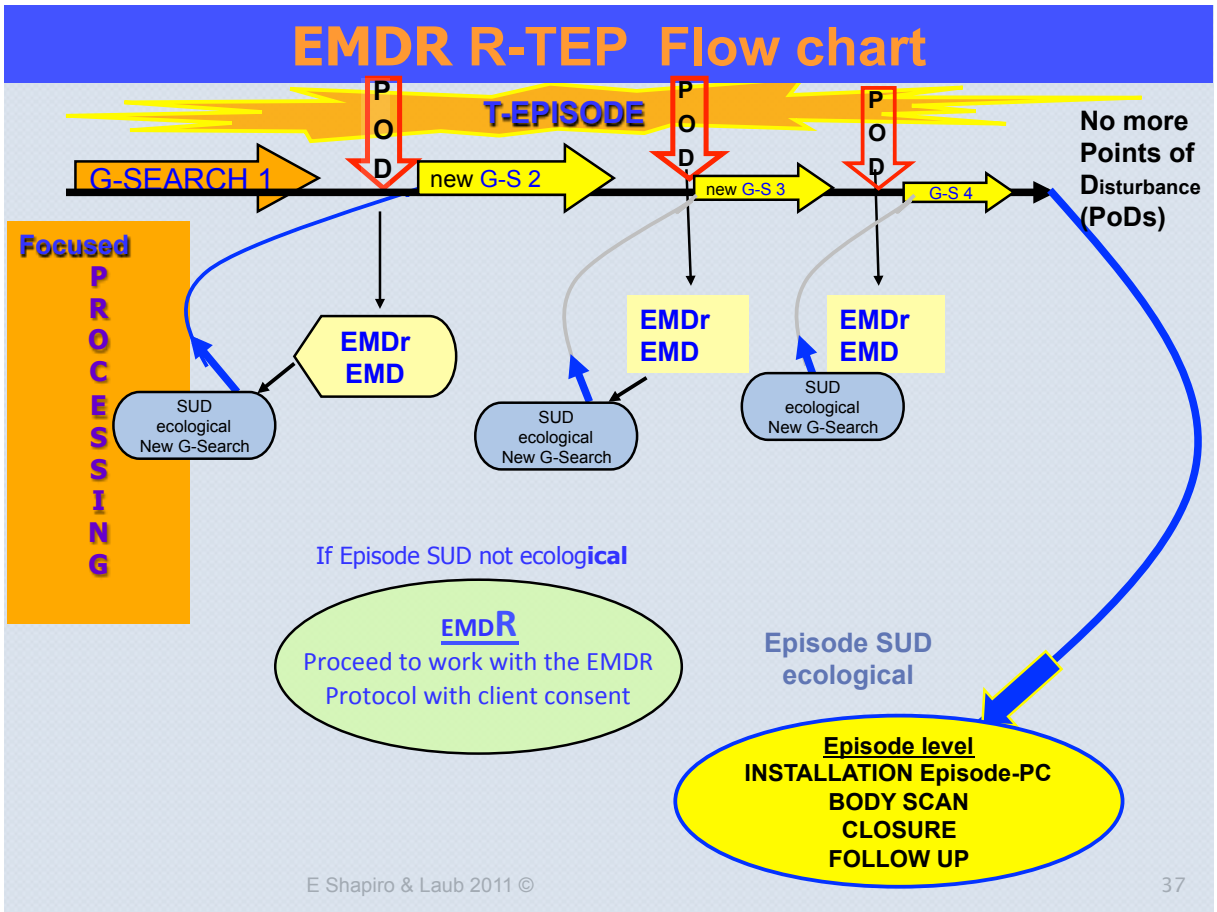
EMDR R-TEP Flow chart
T-EPISODE
P O D
G-SEARCH 1
new G-S 2
new G-S 3
G-S 4
No more Points of Disturbance (PoDs)
Focused PROCESSING
EMDr EMD
SUD ecological New G-Search
If Episode SUD not ecological
EMDR
Proceed to work with the EMDR Protocol with client consent
Episode SUD ecological
Episode level
INSTALLATION Episode-PC
BODY SCAN
CLOSURE
FOLLOW UP
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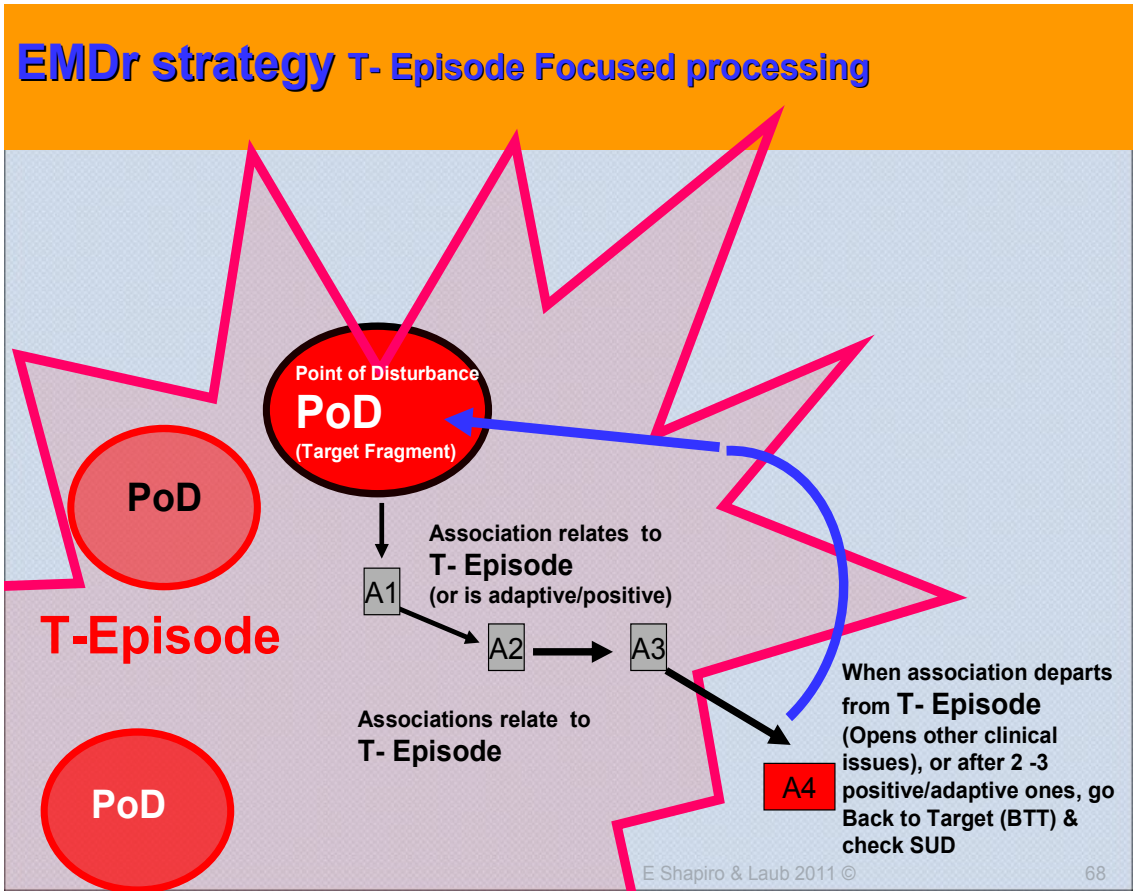

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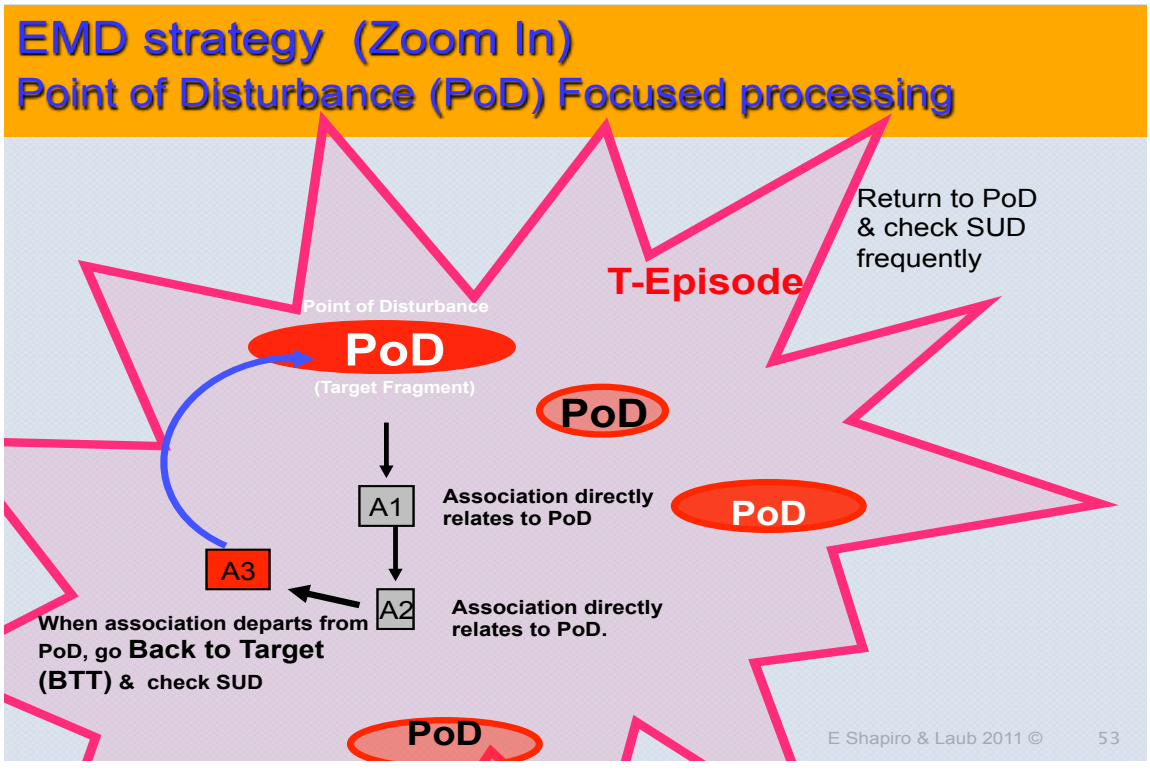

COMPARISON TABLE Standard EMDR Protocol vs. R-TEP

	Standard EMDR Protocol	**EMDR R-TEP**			
Phase I History	Full Intake 3 Pronged orientation Past Present Future. Targets identified for treatment plan	Briefer Intake history: to assess SMS (Severity/Motivation/Strengths), Therapy contract has current Trauma Focused priority. Concept of **T-Episode** Only general information about the T initially (details only requested later during Episode Narrative + BLS)			
Phase II Preparation:	Safe Place (More if needed)	Extended preparation e.g. 4 Elements (includes Safe Place), Resource Connection.			
Phase III Assessment	**Target**: Event Image; NC; PC; VoC; Emotion; SUD; Body	a) **Episode Narrative + BLS** b) **G-Search with BLS** to identify **Target** fragments /Points of Disturbance (PoD). c) FOR EACH PoD: Image; NC; PC; VoC; Emotion; SUD; Body			
Phase IV Desensitization	Processing with BLS No limitations of association as long as there is change	**Focused Processing** : 2 main strategies of expanding focus of associations, EMD<→EMDr EMD – processing of intrusive fragments EMDr- the main strategy	EMD strategy Narrow focus going only with associations relating to the PoD but returning to Target (PoD) & checking SUD when it departs from PoD. If SUD stuck after 6 sets expand naturally into EMDr strategy →	EMDr strategy Wider focus allowing associative chains relating to the T-Episode If SUD stuck consider narrower EMD strategy focus & interweaves	
Phase V Installation	Install PC when SUD 0/1	Install PC (for each Target when SUD is ecological)			
Phase VI Body Scan	Body Scan	No Body Scan until all the targets of the T-Episode processed			
Phase VII Closure	Closure	Strong closure at the end of each session (usually requires several sessions)			
Phase VIII Reevaluation	next session	Check for remaining PoDs using G-Search at next session. Follow-up at end.			

EMDR R-TEP PROTOCOL INSTRUCTIONS

The special circumstances of early interventions requires sensitivity and flexible application of the protocol guidelines.

Phase I: INTAKE (evaluate readiness)

"SMS" ratings

Obtain as much client history as is reasonable in the circumstances to get an idea from the client or from others, of previous functioning, prior trauma history, observe response to Phase II calming exercises etc., sufficient information to estimate SMS ratings on a 5 point scale 1-5 Lo to Hi (S=Severity, M=Motivation, S=Strengths). In addition to the nature of the trauma, gauge risk factors & decide whether it is appropriate to proceed with EMDR processing with this client at this time.
If possible administer the **PCL 5** as part of the evaluation.

Summary of SMS ratings based on all information obtained & clinical impression
S=Severity (Lo) 1 2 3 4 5 (Hi)
M=Motivation (Lo) 1 2 3 4 5 (Hi)
S=Strengths (Lo) 1 2 3 4 5 (Hi)

Phase II: PREPARATION (attention to safety & containment)

In Early EMDR Intervention, clients are likely to be easily flooded with states of high arousal and distress. Therefore phase II preparation is particularly important for establishing sufficient safety and containment to enable starting to work on the protocol.
In all cases start with teaching self stabilisation and resource exercises such as: The 4 Elements, Safe place, and Resource Connection, for calming and enhancing control.
Therapy contract: priority will be given to maintaining a recent trauma focus. Consent will be requested if it is found necessary to broaden the intervention to regular EMDR.

Explanation ***EXPLANATION: "The work we will do here is designed to focus on your recent difficult experiences with the aim to help your natural system digest the parts that are still disturbing so that you can regain your balance. Let whatever comes to mind come up. Sometimes I will ask you to go back to a certain part of the memory, to let your system process and digest that piece. It is like Zooming In, or Out, which can help you focus observe and process your memories and experiences, so that past and present are not confused and you can begin feeling calmer, safer and more in control."***

Focused Processing at Points of Disturbance (PoDs) level

Identification, assessment & processing of each PoD within the Traumatic Episode one at a time. (Phases III, IV, V & VII -no VI)

1. T-Episode Narrative + continuous BLS (Bi-Lateral Stimulation)

Telling the story of the Traumatic Episode (T-Episode) out loud with BLS, from the original incident until today, including disturbing thoughts about the future, which need to be processed.

Option: Using a distancing metaphor, e.g. T.V screen, gives additional containment.

"I am going to ask you to view the whole disturbing episode, ***beginning some time before it started until today. Feel your feet on the ground, the safety of this room, and tell the story out loud****".*
[OPTION "and watch the whole episode as on T.V. Imagine that you are watching it on a screen with a remote control that can make the screen smaller, further away, lower the volume or even stop it"]

2. Episode G- Search with BLS - to identify Points of Disturbance (PoDs) relating to the T-Episode from the original incident until today

"Now, without talking out loud, scan the whole episode, like "Google Search" in the computer, ***for anything that is still disturbing now****, 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."*

Use continuous BLS during the *G-Search*

3. Phase III: Assessment of PoD

ASSESSMENT of each Point of Disturbance (PoD), which becomes the target fragment.

Use as much of the **Standard Protocol** assessment as appropriate (use clinical judgement)
NOTE: When there is high arousal or activation and/or the PoD is an intrusion, flexibility is advised and a partial Assessment may be conducted.

Phase III: ASSESSMENT of PoD

1.TARGET (PoD): *"Describe what is disturbing you" (PoD)*

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2. Image:

If the PoD is not a visual image ask:
"Is there a picture which goes with this PoD?"

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3. NC (Negative Cognition):
"What negative words go with that PoD…,or about yourself, now?"
.....

If high arousal &/or difficulty in rapidly finding an NC, suggest a suitable NC
"A lot of people who have gone through situations similar to what you went through often report afterwards that they are left with negative thoughts or judgments about themselves, like: 'I can't believe it happened' ;I'm not safe' ; 'I'm helpless; 'I didn't do enough', and so on. What kind of thought occurs for you?

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4. PC (Positive Cognition) *"When you bring up that PoD … how would you like to think about it, or about your self, now ?"*
.....

If it is difficult to find a PC while the level of disturbance is high, offer a tentative PC which is appropriate to the NC: e.g. "*Would you like to believe that…"it happened & it's over, I survived, I am safe now from THAT event…I can cope, I did the best I could". Is that what you would like to believe or is there something else you prefer?*

5. VOC *"On a scale of 1 to 7, where 1 is completely not true and 7 is completely true, how true do these words feel to you, now?"* 1 2 3 4 5 6 7

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6. Emotions: *"When you bring up that PoD … and those words (NC above), what emotion(s) do you feel now?"*

7. SUD: *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the (PoD)…….. feel to you now?"*

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

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8. Location of Body Sensation:
"Where do you feel it in your body?"

4. Phase IV: FOCUSED PROCESSING (Desensitization)

5. Phase V: INSTALLATION

EMDr strategy - This is the main strategy of the Telescopic Processing. In this strategy the associative span of the Adaptive Information Processing (AIP) system relates *to the current traumatic episode.* If an association comes up which is not related to the traumatic episode the client is asked to re-focus by going Back To Target (BTT) to the Pod *(Point of Disturbance)* and checking the SUD.

The EMD strategy – This is a narrow focused strategy which allows only associations related to the PoD. If the association is not directly related to the PoD the client is asked to re-focus by going BTT and checking the SUD frequently.

The EMD strategy is advocated:

a) When the target/ PoD (Point of Disturbance) is an intrusive fragment (frequently recurring disturbing Image, sensation, thought, feeling). **But if the SUD is not reducing significantly after about half a dozen sets then expand naturally into an EMDr strategy.**

b) When there is still an intrusive/painful fragment which blocks the AIP system, or when the SUD level is not reducing with the EMDr strategy, consider narrowing to an EMD strategy as one procedure which can be attempted to get the processing moving (in addition to interweaves).

c) In very early interventions, and possibly when working with children, the narrow focus EMD strategy may be preferred.

THIS IS THE MAIN STRATEGY of the FOCUSED PROCESSING

EMDr Strategy – Traumatic Episode Focused processing

INSTRUCTIONS

"I'd like you to Zoom In to the Point of Disturbance (PoD) …think of those negative words (repeat the (NC), and notice where you are feeling it in your body"… Then do a set of BLS (Bi-Lateral Stimulation) After set: *say "Take a deep breath.….What do you get now?".....*

a) If the association is about the Traumatic Episode
say *"Go with that"* … and continue with sets of BLS, and chains of association as long as the association is related to the episode

b) If the association departs from the Traumatic Episode - *go back to Target (PoD)*
say "we can note that but as we have agreed to focus on the recent episode I will ask you now to go back to the Point of Disturbance ....(PoD: image/sensation/feeling/or thought etc.), What do you notice now?.....How much disturbance do you feel now from 0 to 10?"
0 1 2 3 4 5 6 7 8 9 10 Then do another set of BLS

Continue the processing in this way until the SUD level drops to an ecological level or PoD can be viewed calmly.

Go on to do the Phase V: INSTALLATION for this PoD **(Do the Installation in the usual way checking the PC & the VoC [1…..7] and installing it as close to 7 as it will go)**

If the SUD level is not reducing or processing gets stuck then, consider using the EMD strategy for more focused processing and/or use interweaves.

Continue by repeating the "Episode G-Search" as before to check if there are any other PoDs left within the T-Episode to be processed similarly with Focused Processing

*"Now, again without talking out loud, return to scan the whole episode, like "Google Search" in the computer, **for anything else which is disturbing**, 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 now and we will process it."*

Use continuous BLS during the *G-Search*

EMD Strategy: Point of Disturbance (PoD) narrow focused processing

Use this strategy primarily:
When the Point of Disturbance (PoD) is an intrusive image/sensation, feeling or thought
When the EMDr processing is arrested (stuck)
When the intervention is very early (first week or two)

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 frequently.
The 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 6-8 sets "Zoom Out" smoothly to a wider EMDr strategy.

INSTRUCTIONS

"I'd like you to Zoom In to the Point of Disturbance (PoD: image/ /sensation/feeling/or thought etc.)…think of those negative words (repeat the (NC), and notice where you are feeling it in your body"… ,

Then do a set of BLS (Bi-Lateral Stimulation)
After set: *say "Take a deep breath. …What do you notice now?".....*
……...

a) If the association is about the *PoD*,:
say "Go with that" … then do another set of BLS.

b) If the association departs from the *PoD go back to Target (PoD)*
say: "I would like you now to re-focus briefly on the Point of Disturbance (PoD: image/ /sensation/feeling/or thought etc.) to help your natural system digest it, "What do you notice now?" ..... /or, "Has anything changed?"...../ "How much disturbance do you feel now from 0 to 10?"

0 1 2 3 4 5 6 7 8 9 10 …then do another set of BLS.

And so on… continue for several more sets.

When SUD level reduces to ecological validity or the original **PoD** can be viewed relatively calmly **proceed directly to do the Phase V INSTALLATION** for this PoD. (Do the Installation in the usual way checking the PC & VoC [1…7] and installing it as close to 7 as it will go)

If the SUD level is not reducing sufficiently, after about 6-8 sets**,** then "Zoom Out" smoothly to the **EMDr** strategy (below) which permits wider associations relevant to the **current Traumatic Episode**

NOTES:

Since the T-Episode is comprised of several Target fragments (PoDs) the G- Search is usually used over several sessions.

Ensure a strong closure at the end of each session!

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

Rarely the current trauma focused processing is not sufficient for adaptive resolution consider the option to suggest using the EMDR standard protocol, with client consent establishing a new contract.

EPISODE LEVEL

Checking Episode SUD (E-SUD)

When no more targets (PoD) emerge with G-Search
check the **SUD level for the entire T-Episode**.

"*When you think of the entire episode now, how disturbing is it to you on a scale from 0 to 10?"*…….

When the Episode SUD level is "ecological" (realistic) proceed to Installation of Episode PC

NOTE: Rarely, if the Episode SUD is not ecological, inquire what is preventing it or what would be needed to reduce it. Consider using interweaves, doing an additional G-Search or it may be necessary to work with the Standard EMDR Protocol for underlying issues, **with client consent**.

Phase V: INSTALLATION of Episode Positive Cognition (E-PC)

"When you look at the original incident and all that has happened since, the entire episode, how would you like to think about it now? What have you learned from it?" ……..

Obtain an E- PC for the entire episode

Check the VOC. - "*When you think of the entire episode again and say the words (repeat the E-PC), how true does it feel to you on a scale from 1 to 7?"*…..

Episode Installation with BLS

"*Hold them together, the entire episode and these words…….. (E-PC)*"

Install with sets of BLS checking VOC.

Continue installation until it no longer changes or VoC is 6 or 7 If

Phase VI: EPISODE BODY SCAN

"When you think of the entire episode and your positive cognition… (state E-PC), notice any body sensations.

Use sets of BLS focusing on the body as in the Standard Protocol

Phase VII: EPISODE CLOSURE (as in Standard Protocol)

Arrange for follow-up

Phase VIII: FOLLOW - UP

Obtain feedback from previous work and check Episode SUD Level (0……10)

If not ecological: use G-Search to identify any residual Targets (PoD) that may require additional processing.

If ecological: confirm appropriateness of Episode-PC ……

Check & reinforce VOC (1…….7)

Administer the PCL 5 again **at end of treatment & at follow-up (after about 3 months)**

Check level of functioning again at post treatment & at follow-up

(POST) Level of Functioning (compared to usual) [LO] 1.…2.…3.…4 [HI]

(FOLLOW-UP) Level of Functioning (compared to usual) [LO] 1.…2…3.…4 [HI]

PCL 5 Scoring

TOTAL SCORES: PRE_____POST_____

FOLLOW-UP_____

COMMENTS (continue on other side of page)

_____

_____

_____

_____

DATA COLLECTION

Phase I: History (INTAKE)

A. Date today: _____Date of trauma:_____Time since trauma:_____

Clinician: _____Client's name / initials/ no:_____1. M / 2. F

Contact Phone no: _____email:_____

Age:____Family status:_____Education (no. of years):_____

Employment: 1.working 2. not working_____

_____

B. Type of intervention: 1. R-TEP_____2. Other (specify)_____

Recent Traumatic incident or incidents _____

Medication 1. No 2. Yes (specify + when started)_____

_____

Physical injury: 1. No 2. Yes (specify type + severity)
_____

Level of Functioning (compared to usual) [LO] 1.…2..…3..…4 [HI]

Previous psychological treatment: 1. No 2. Yes (specify)_____
_____

C. Previous trauma history

Event _____date (year)_____

Event _____date (year)_____

Event _____date (year)_____

D. Preparation: (Poor) 1……5 (Excellent)

E. "SMS" evaluations: [LO] 1...…..5 [HI]: **Severity….Motivation….Strengths….**

COMMENTS (continue on additional pages)
_____
_____

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
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10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
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3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
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14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4