

Early EMDR Intervention (EEI)

A Summary, a Theoretical Model, and the Recent Traumatic Episode Protocol (R-TEP)

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This article examines existing early EMDR intervention (EEI) procedures, presents a conceptual model, and proposes a new comprehensive protocol: the Recent-Traumatic Episode protocol (R-TEP). A review of research and important professional issues regarding application and parameters are presented. The commonly used EEI protocols and procedures are summarized, with the inclusion of descriptive case examples from the Lebanon war and a review of related research. Then a theoretical model is presented in which traumatic information processing is conceptualized as expanding from a narrow focus on the sensory image (perceptual level) to a wider focus on the event/episode (experiential level) and finally to a broad focus on the theme/identity (meaning level). The relationship of this model to the Recent-Traumatic Episode protocol is articulated and case examples are presented. Theoretical speculations are discussed relating to attention regulation and the Adaptive Information Processing (AIP) model. Further research is encouraged.

Keywords: EMDR; early EMDR intervention; recent trauma; Adaptive Information Processing model; posttraumatic stress disorder (PTSD); prevention of PTSD

Every story has a beginning, a middle, and an end—but not necessarily in that order.

—(attributed to Jean Luc Goddard)

Every trauma has a past, a present, and a future—but not necessarily in that order.

—(Authors)

The first section of this article focuses on the issues related to early EMDR intervention (EEI). The ethical issues arising from early intervention after a recent traumatic event are discussed and questions about the appropriateness and utility of EEI are addressed. This is followed by a summary of early EMDR interventions, including several case examples illustrating their application and a brief review of related research.

Professional Questions

Early EMDR (eye movement desensitization and reprocessing) intervention following a traumatic event raises a number of professional questions. There are concerns about the risk of pathologizing a normal response to an abnormal situation and ethical issues about the therapeutic contract when intervening with EMDR soon after a critical incident. It should

be remembered that most of the clients seen following a recent trauma would not have sought or been offered treatment otherwise. However, some may also have previous trauma and mental health histories. This has implications regarding the therapy contract. Clinicians are cautioned to attend to a general risk of cutting corners such as insufficient history taking/intake and insufficient rapport and preparation. In particular, there are specific risks concerning brief, emergency EMDR interventions such as a lack of containment and a possibility of opening up other clinical issues. With EMDR we know where we start but not where we will go, and intense emotions are frequently evoked. In addition, follow-up may be neglected. The self-healing, minimal intervention philosophy of EMDR could come into conflict with a temptation to rush into early EMDR interventions. However, EMDR clearly has much to offer for aiding recovery following trauma. Consequently, the way in which early EMDR intervention is conducted needs to be carefully considered.

While working with victims of the Lebanon war in the summer of 2006, in which large civilian populations came under missile attack, the authors with other EMDR practitioners in Israel felt an urgent need to consider early intervention with EMDR. The main early EMDR intervention (EEI) protocols were examined and compared to discern what characterizes and distinguishes them, what is their appropriate application, and how the professional concerns raised above can be addressed.

Why Early EMDR Intervention?

According to the National Institute for Clinical Excellence (N.I.C.E.) U.K. Clinical Guidelines (2005) for treatment of posttraumatic stress disorder (PTSD), the probability of developing PTSD following a traumatic event is 8% to 13% for men and 20% to 30% for women, with an annual prevalence of 1.5% to 3%. Many recover without treatment within months/years of an event, with 45% to 80% showing natural remission at 9 months. Generally 33% will remain symptomatic for 3 years or longer with an increased risk of secondary problems.

Natural recovery following disasters may also be painfully prolonged, lasting as many as 18 months (Norris et al., 2002). Thus despite reassurance that a majority of people exposed to traumas will recover, there are still a large number who become impaired with clinically significant symptoms and many more with subclinical symptoms. These findings support the notion of early intervention. Therefore if there is a possibility of avoiding the development of PTSD, or of relieving excessive suffering, by means of a relatively simple procedure such as early intervention with EMDR, this is well worth exploring.

Overview of Existing Early EMDR Intervention (EEI) Protocols

The memory of a recent trauma differs from that of a more distant trauma in that it tends to be more fragmented, disorganized, and less integrated into a coherent narrative or sequence of events. Consequently, it may not be adequately represented or generalized by any single image from the event (F. Shapiro, 2001). Further, according to the model presented in this article, it may not yet be organized into a theme cluster. Therefore, when working within several weeks and possibly months following a traumatic event, it is necessary to modify treatment procedures to address these factors.

The main protocols proposed for early intervention are the EMD (eye movement desensitization) protocol and the Recent Event protocol (F. Shapiro, 2001). Table 1 places these protocols, as well as other EMDR relevant early intervention procedures, along a timeline from 2 days following a traumatic event to 3 months and more following the diagnostic indications for acute stress disorder (ASD), acute PTSD, and chronic PTSD (American Psychiatric Association [APA], 1994). Note that these categories are only approximate and that in practice there is a continuum with overlap.

Eye Movement Desensitization (EMD)

The EMD protocol, as its name suggests, differs from the standard EMDR protocol in that it focuses on the desensitization of the intrusive sensory image, returning to it and frequently checking Subjective Units of

TABLE 1. Principal Early EMDR Intervention (EEI) Protocols

Time After "T"	2 Days...>	2 Weeks...>	1 Month...>	3 Months...>
Diagnosis	ASR	ASD	Acute PTSD	Chronic PTSD
Main Protocols	ERP	EMD	RE protocols	Standard protocol
Other Protocols	EMDR-ER; Kutz protocol	Group (EMDR-IGTP); Kutz	Group (EMDR-IGTP)	

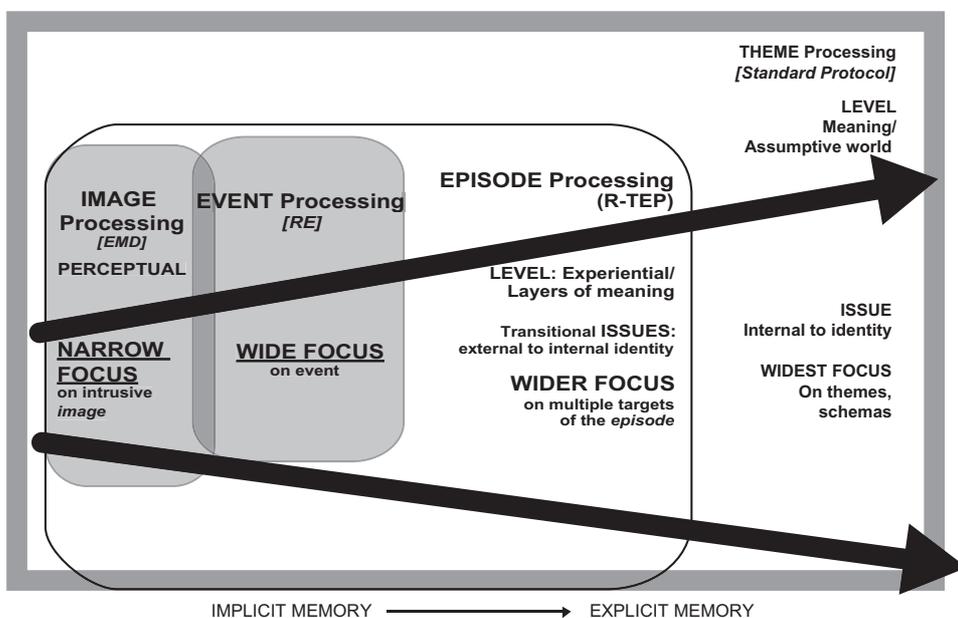


FIGURE 1. Early EMDR interventions (EEI): The widening focus of image-event-episode-theme processing.

Disturbance (SUD) level (where 0 = no disturbance and 10 = worst disturbance possible). This process thereby limits associative chains. EMD is conceptualized by the authors as a protocol primarily utilized for treating intrusive symptoms of ASD, usually intrusive pictures, sounds, smells, and other repetitive sensations, referred to here as “sensory images,” addressing stuck processing at the perceptual level, as illustrated in Figure 1.

EMD is described in the *Military & Post-Disaster Response Manual* (F. Shapiro, 2004) as follows:

Sensory disturbance interfering with . . . functioning can be addressed with EMD that focuses directly and repeatedly on the target (e.g., intrusive image, explosion, smell).

After each set (12–24 movements), client is told “Blank it (the picture) out, and take a deep breath.” The client is then asked to bring up the picture and words again, to concentrate on the sensations generated, and to provide an SUD level rating from “0” to “10.” At the times the SUD levels are taken, clients are occasionally asked such questions as “Did the picture change?” or “What do you get now/Does anything else come up?” Their answers are used as a barometer of change since they often reveal new insights, perceptions, or alterations of the picture (e.g., “The picture seems further away”; “I didn’t do anything wrong”). If an answer reveals that a new associated limiting belief has arisen, this belief is often included with the original statement during the next set (p. 2).

CASE: USING THE EMD PROTOCOL IN THE LEBANON WAR

Miriam, a mother of three, was exposed to a traumatic event during the war. Previously well functioning, she asked for professional help because she was still suffering from nightmares and sleep disturbances several weeks later. The traumatic event was a fall of a missile in the house yard when the family was on its way to the shelter. Miriam’s leg was injured from shrapnel and she fell down. The daughter, who was hand in hand with her, was thrown from the blast to another place. Some minutes later they met and both parent and daughter went down to the shelter.

In the assessment phase of EMD, Miriam identified the intrusive image of her daughter suddenly disappearing, together with a sensation of terror and the thought that she is dead. The session started with the 4 Elements exercise for stress management (E. Shapiro, 2007) followed by the EMD protocol, with a distancing metaphor of viewing as on a TV screen. Miriam started with SUD = 10. The SUD level was checked after every set and it went down gradually to 3. In the third set the image started to disappear from time to time, in the fourth she recalled other details of the event and the picture got larger on the TV screen. On the fifth set she didn’t need the distancing any more: “I went back there without the TV screen and it was OK. I remain relaxed, I am part of it.” In the sixth set many details were elicited, some of which she had not previously remembered. Miriam continued processing the event chronologically, from the moment she was hurt onward. In the last set

she described with a smile the gathering of the neighbors in the shelter nurturing each other: "The event is not in the center any more." Finally she ended with a future Resource Connection (Laub, 2001) in which she imagined preparing her older daughter's wedding in the house yard (the location of the trauma) where she was watering the bombed tree (which had started to grow).

Recent Event (RE) Protocols

Recent Event (RE) protocols conceptualize the traumatic *event* as a fragmented experience, which has not yet consolidated so that no single image can represent the entire event. It is therefore necessary to process a number of targets, which are aspects or parts of the event, in order to facilitate integration and consolidation (F. Shapiro, 2001). There are several versions of the RE protocol: the extended Protocol for Recent Traumatic Events developed by Francine Shapiro (2001), a version of it in the *Military & Post-Disaster Response Manual* (F. Shapiro, 2004), and the Recent Traumatic Event protocol (RTE), a modified version based on Roger Solomon's workshops (E. Shapiro, 2003). The authors of the current article conceptualize these similar protocols as having a wider focus, usually utilized for treating ASD and acute PTSD focusing on various aspects of the single traumatic event that are disturbing, predominantly at the experiential level (emotion, somatic sensations), in addition to the intrusive sensory images.

The extended Protocol for Recent Traumatic Events (F. Shapiro, 2001) instructs the client to obtain a narrative history, target the most disturbing aspect of the memory, and then identify targets reported from the remainder of the narrative in chronological order. The client is asked to mentally visualize the entire sequence of the event with eyes closed to identify remaining disturbing targets for processing. Each target is given the standard EMDR procedure except for body scan. This is repeated until the entire event can be visualized from start to finish without disturbance.

The Recent Trauma protocol is outlined in the *Military & Post-Disaster Response Manual* (F. Shapiro, 2004) as follows:

Recent traumatic events often have not had the time to consolidate. Therefore, it is necessary to target each aspect of the traumatic ("T") event separately. Each aspect of the event needs to be assessed for its own image, negative cognition, positive cognition, VoC, emotions, SUDs, and body sensations.

Obtain a narrative history

Identify each target

Image, NC, PC, VoC, emotion, SUD, location

Desensitize most disturbing target

Desensitize remaining targets in chronological order

Have client visualize the entire sequence of the event with eyes closed and desensitize it as disturbance arises. Repeat until the entire event can be visualized from start to finish without disturbance

Have client visualize the event from start to finish with eyes open and install positive cognition (p. 5)

Recent Traumatic Event (RTE) Protocol

The Recent Traumatic Event (RTE) protocol was based on Roger Solomon's critical incident workshops (E. Shapiro, 2003). It essentially modified the protocol for recent traumatic events to structure it along parallel lines to the eight phases of the standard EMDR protocol where possible. This familiar structure was adopted to facilitate rapid teaching and assimilation of the protocol to EMDR-trained practitioners in emergency situations who are unfamiliar with it while also reminding them to attend to the good practice guidelines of the eight phases. This protocol was made available to EMDR practitioners during the Lebanon war.

CASE: WORKING WITH THE RTE PROTOCOL IN THE LEBANON WAR

Rachel, a religious woman, was a single parent with three children. Two months after the war she suffered from high anxiety and stress. The session began with the 4 Elements exercise for stress management (E. Shapiro, 2007), followed by the EMD protocol with a distancing metaphor of a TV screen. She chose one intrusive image, in which the blast from a missile damaged the windows of her flat. Her SUD score decreased gradually from 10 to 3. However, at the end of the session, she recalled other traumatic events from the 2 weeks in the bombed city and the SUD went up. The EMD protocol was therefore not sufficient to complete the processing. At the second meeting the RTE protocol was employed that processed several targets from the 2-week-long traumatic event and included video visualization to identify residual disturbances. She finished the session with SUD = 1 and PC: "God is guarding me and I am protected," which expressed her renewed faith and confidence.

Emergency Room Protocols

Three Emergency Room (ER) protocols are described here: the Emergency Response protocol (ERP; Quinn, 2007), the EMDR-ER (Guedalia & Yoeli, 2003), and Kutz's (in press) Modified Abridged EMDR protocol. The authors of the current article consider these ER interventions as augmenting stabilization (phase II) and promoting initial processing.

Emergency Response Protocol (ERP)

In his Emergency Response protocol (ERP), Quinn (2007) reported positive results with the use of bilateral stimulation (BLS) combined with supportive positive cognitions (e.g., "it's over, you are safe now"). The ERP protocol was provided in the hospital emergency room following terrorist attacks to victims who were presenting with extreme responses and who were unable to communicate because of severe distress.

The ERP is outlined in the *Military & Post-Disaster Response Manual* (F. Shapiro, 2004) as follows:

Overwhelming affect presenting as dissociation or hallucinations within hours of the event can be directly targeted.

Bilateral stimulation is applied with positive cognitions until the client is able to produce a narrative.

For high but not overwhelming affect, BLS can be used in short sets to take off the edge. Psychoeducation may then be sufficient (p. 2).

EMDR-ER

Guedalia and Yoeli (2003) developed another protocol to be used in the emergency room following their experience with suicide bombing victims. This protocol, which they called EMDR-ER, was used with patients still on gurneys, who were unable to move on to the ambulatory staging area and who displayed difficulty in functioning. The focus in this protocol was on installation of positive cognitions and for the therapist to assist in creating a narrative of the traumatic event so that the patient had a "speech-full" coherent account with generally appropriate affect. The goal was to get the patient up and out of the emergency room.

The Kutz Modified Abridged EMDR Protocol

The Kutz protocol is viewed as a variant of the EMD protocol. Kutz described it as a single session "modified abridged EMDR protocol," with Alternating Bilateral Stimulation (ABS). It is usually provided in a

hospital setting, sometimes in the ER, although more usually some days or weeks later to patients with acute stress syndrome who present with unusual responses following terrorist attacks or motor vehicle accidents (Kutz, 2006).

Group EMDR Protocols

Group EMDR protocols were included in Table 1 as they have been applied in emergency disaster situations in which there are many victims and few practitioners available so that individual intervention is limited. The EMDR Integrative Group Treatment protocol (EMDR-IGTP; Jarero, Artigas, & Montero, this issue) was originally designed for working with children and was modified later for use with adults. It utilizes the Butterfly Hug as a form of self BLS initiated by Artigas, together with drawings for group processing. Working mostly with small groups of children and an emotional support team of mental health personnel, EMDR-IGTP begins with a preparation phase to establish rapport and trust, which includes a safe place exercise. The children are asked to think about disturbing aspects of the event, to draw it, and then to perform the Butterfly Hug. This process is repeated three more times, with the child each time drawing another picture that they rate using an SUD Scale. At the end they are asked to draw a positive picture together with a word or a phrase, which is installed with the Butterfly Hug.

The authors of the current article regard the group procedures as valuable in certain disaster circumstances where individual interventions are not feasible or restricted and for screening for persons who will require further individual attention. They may be beneficial as a means of gaining more control over anxieties and getting in contact with coping resources.

Research on Early Treatment Interventions

Very few randomized controlled treatment studies have been reported for early intervention following trauma (Bisson, 2006; Bryant, 2000). Bisson described nine trials of early psychological intervention and three trials of early pharmacological intervention. He concluded that there is emerging but limited evidence of clinically important effects with trauma-focused cognitive behavioral therapy (CBT), administered 1–3 months following a trauma. There is no convincing evidence of the effectiveness of pharmacological interventions or of debriefing. It is noted, however, that there is a methodological difficulty in demonstrating effectiveness because of the high percentage of spontaneous recovery expected after trauma.

EMDR

There have been no randomized controlled studies with early EMDR intervention; however, there are some nonrandomized controlled studies. Victims of Hurricane Andrew were given one session of EMDR two and a half months following the disaster. Despite the limitations of the study in disaster conditions, the results were promising, showing significant improvements in the EMDR group as compared to the waiting-list controls (Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997).

A study was conducted on the use of EMDR following the 9/11 terrorist attacks in New York in 2001 (Colelli & Patterson, this issue; Silver, Rogers, Knipe, & Colelli, 2005). Again, due to research difficulties in disaster situations, the researchers used an analog wait-list control group to compare symptom levels after treatment of the “early group” (2–10 weeks following trauma), as well as of a “late group” (30–48 weeks after). The treatment consisted of an average of four to five sessions of EMDR. The results showed significant positive gains on a number of outcome measures in both treatment groups. It is interesting to note that those who sought treatment at the later date presented with higher levels of distress than those who were treated in the first few weeks. Silver et al. concluded that “EMDR is a useful treatment intervention both in the immediate aftermath of disaster as well as later” (p. 29).

Ad de Jongh (2005) has reported encouraging results with very early EMDR interventions (several days after the incident) with crime victims in the Netherlands. Quantitative data is currently being collected.

Single-Session Modified Abridged EMDR Protocol

Ilan Kutz (in press) has provided initial data from multiple case studies using what he calls a single-session “modified abridged EMDR protocol,” with BLS applied to patients with ASD following road accidents and terrorist attacks. He found that 77% of the 86 patients showed immediate or marked relief of their intrusive and other distress symptoms. Most of the responders were victims of a single traumatic event.

Recent Event Protocols and EMD

There are no published studies relating to the use of EMDR Recent Event protocols or EMD protocol in its application for early intervention. A pilot study evaluating EMD was initiated by Ilan Kutz, in collaboration

with the EMDR-Israel Association. They contacted people who had been admitted to hospital emergency rooms suffering from extreme stress responses after missile attacks during the 2006 Lebanon war. Those who still had symptoms several weeks later were offered a single session of EMD and follow-up. The sample was small and all participants in this sample were exposed to repeated shelling and multiple traumatic events for more than 4 weeks. The results were inconclusive for various reasons, but it seems that treatment was helpful in the short term on a number of measures. There was some erosion of gains at a 3-month follow-up (Kutz, 2006).

EMDR Integrative Group Treatment Protocol (EMDR-IGTP)

The EMDR Integrative Group Treatment protocol (EMDR-IGTP; Jarero et al., this issue) was originally developed for the survivors of Hurricane Pauline in Acapulco, Mexico, in 1997. This protocol utilizes the “Butterfly Hug” as a form of self BLS, together with drawings for group processing. Field study reports from various parts of the world lend support to the benefits of using EMDR-IGTP in mass disaster situations (Jarero, Artigas, & Hartung, 2006). The group protocol was used with children in Turkey after the 1999 earthquake (Korkmazlar-Oral & Pamuk, 2002), with children in Thailand who survived the December 2004 tsunami (Birnbaum, 2007), as well as with groups of Kosovar-Albanian refugee children in Germany (Wilson, Tinker, Hofmann, Becker, & Marshall, 2000). In a nonrandomized study, 236 schoolchildren with PTSD symptoms after witnessing a plane crashing into a building in Milan received EMDR-IGTP 30 days after the incident. Nearly all the children were reported to be functioning normally at 4 months follow-up (Fernandez, Gallinari, & Lorenzetti, 2004). In a modification (Laub, in press), EMDR-IGTP was combined with the 4 Elements stress management exercise (E. Shapiro, 2007) and employed with groups of distressed children following ongoing missile attacks in Israel (Bar-Sade, 2007).

Considerations When Using Early EMDR Intervention

There appear to be at least three main issues to consider when intervening with EMDR soon after a critical traumatic incident. First, the nature of the recent trauma memory itself: fragmented, not integrated. Second, the nature of the situation: stressful for client and therapist, sense of urgency/emergency, risk of high arousal with re-experiencing/flooding and the

need to contain and keep the client safe. Third, the nature of the therapeutic context: professional issues involving the therapy contract, and scope of the intervention, which can be limited to the trauma or extended to other clinical issues.

Existing EEI protocols give guidelines and suggestions relating to the first issue of the fragmentary nature of the recent trauma memory. While EEI protocols provide a good basis for approaching this issue, the authors suggest that they are incomplete. Clinical experience showed that they could fall short of encompassing all the levels at which processing could become stuck. They omit a systematic targeting of disturbances subsequent to the traumatic event itself. It was not always clear when to use which EEI protocol or whether to comply with the standard protocol.

The second and third issues were not adequately addressed. The fact that the client may be easily triggered into re-experiencing intense emotional states requires including additional measures within the protocols for stabilization and regulation to contain and keep them safe when working soon after traumatic incidents. In the stressful circumstances usually associated with EEI, the therapeutic context and goals could be overlooked. EMDR phases I and II (history and preparation) could easily be neglected and the therapeutic contract left vague and unclear.

Another aspect concerns therapist issues and common difficulties faced by therapists working in emergency situations. These challenges include over-identification with the victim and fear of causing harm and can lead on the one hand to collusion with the client in avoidance of relating to the trauma and on the other hand to burnout or compassion fatigue (Lahad, 2000). Unclear procedures can contribute to therapist confusion, hesitancy, and avoidance in these circumstances. There is a need for a clear and comprehensive model and set of guidelines in the first aid toolbox of the EMDR practitioner to assist in approaching the prospect of EEI with more confidence.

A broader conceptualization of the traumatic time frame or episode consisting of multiple events/targets seems to be necessary, as well as an effective means of identifying these unprocessed targets. These observations and conclusions lead to the development of a new model and protocol: the Recent Traumatic Episode protocol (R-TEP).

It should be noted that it was the attempt to collect empirical data using the EMD protocol that inspired this article and the development of the R-TEP. This underlines the importance of gathering data about the usefulness of these protocols in order to improve them. However, research is needed to test their effectiveness.

A Theoretical Model

In the first section of this article, the major EEI protocols were analyzed and compared to discern what characterizes and distinguishes them (see Table 2). It was observed that the EMD protocol tended to narrowly focus on intrusive sensory images, which primarily addressed stuck processing at the perceptual level, involving physical survival issues (safety, control). Whereas the RE protocols focused more widely on the various parts of the event, addressing stuck processing primarily at the experiential level of the event, also usually involving survival issues of safety and control, external to identity. When the standard EMDR protocol was extrapolated on this continuum, it was seen to focus broadly on events related to themes at the meaning level, addressing additional issues of psychological survival relating to identity.

It is noted that while the primary focus at each level (perceptual, experiential, meaning) was usually on a particular modality, it is evident that all the modalities (sensory, emotional, somatic, and cognitive) are simultaneously present at each level to some extent, with one or more being dominant.

While the standard EMDR protocol uses a three-pronged approach to address past, present, and future aspects of the event, the EMD and RE protocols can be understood as one-pronged approaches relating primarily to the (recent) past image or event. What has been missing is a two-pronged approach for recent events relating to the past and to the present. This need is fulfilled by the R-TEP, which is introduced in this article. The R-TEP is placed in Table 2 in the column that was “missing” from the existing protocols, illustrating how it provides the missing links bridging the transition from RE protocol to standard protocol.

It is suggested that the focus of these interventions expand from a *narrow focus* on the intrusive sensory image in an Image Processing protocol to a *wide focus* on the parts of an event in an Event Processing protocol, to a wider focus on a series of events in an Episode Processing protocol, to a broad (widest) focus on a series of episodes in a Theme Processing protocol. Figure 1 illustrates this expanding task focus and reinforces a need for an approach that encompasses the narrow as well as the wider focuses.

In the first section of the article, it was concluded that the existing EEI protocols were not comprehensive enough. It was not clear when to use which EEI protocol or whether to stay within the standard protocol. There was also insufficient attention paid to the

TABLE 2. Early EMDR Interventions (EEI)—Protocols Comparison Table

	EMD Protocol <i>IMAGE Processing</i>	Recent Event Protocol <i>EVENT Processing</i>	R-TEP <i>EPISODE Processing</i>	Standard Protocol <i>THEME Processing</i>
STUCK PROCESSING LEVEL	PERCEPTUAL. Sensory image	EXPERIENTIAL. Event	Experiential/layers of meaning Episode (time period from the original event to the present)	MEANING Theme, schema, assumptive world Life pattern
FOCUS	NARROW FOCUS on intrusive sensory image	WIDE FOCUS on disturbing aspects of the event	WIDER FOCUS on disturbing aspects of the entire episode	WIDEST FOCUS on disturbing aspects of a theme, schema
ISSUES	Physical SURVIVAL Safety/Control <i>External to IDENTITY</i>	Physical SURVIVAL Safety/Control/Guilt <i>External to IDENTITY</i>	TRANSITIONAL: from Physical to Psychological <i>SURVIVAL from External to Internal IDENTITY</i>	Psychological SURVIVAL Appropriate Responsibility for past events, Safety in the present, new Choices in the future. <i>Internal to IDENTITY</i>
GOAL	Adaptive absorption & integration of image within event Desensitization	Consolidation of fragmented, unprocessed experiences, integration of event	Integration of unprocessed parts of the episode (the event, experiences after the event, and the changing meaning of the original event)	Integration of unprocessed events into an adaptive theme
MEANS	Repeated targeting of intrusive sensory image Limited associative processing 1-pronged protocol	Processing disturbing aspects of the event. Using “video” (sequential) to identify targets No regulation of associations Extended 1-pronged protocol	Processing disturbing aspects of the episode. Process using “Google Search” (non-sequential) to identify targets Option of regulating associative processing 2-pronged protocol	Reprocessing of disturbing memories associated with the theme Full associative processing 3-pronged protocol

therapeutic context of early intervention and to the consequences of the traumatic event.

This article describes the new protocol, the R-TEP, which is presented here in manualized form for practical application. Case examples are given and its main features are discussed. The development of this protocol evolved together with a conceptual model. This process went hand in hand with theoretical speculations relating to the Adaptive Information Processing (AIP) model (F. Shapiro, 2001) as well as the possible role of attention regulation.

The Recent Traumatic Episode Protocol (R-TEP)

Symptoms of ASD or acute PTSD characteristically show a lack of differentiation of past and present at some level. In the current conceptualization of the model proposed here, the sequence of experiences that has unfolded since the original event is considered part of the continuing *traumatic episode*, which extends into the present time. Within this episode there may be multiple targets that require processing and integration.

TABLE 3. Recent Traumatic Episode Protocol (R-TEP)

Main Features of the R-TEP

Target selection:

- 1) Episode-wide focus = period from the traumatic event to the present
- 2) Use of “Google Search” metaphor to identify multiple targets within the episode (sensory images/events/other experiences)

Containment (safety):

- 1) Eight-phase structure parallel to standard protocol
- 2) Episode narrative with DAS for grounding
- 3) Regulation of associations, option of limiting associations to the image/event/episode

A

PHASE 1: HISTORY

Obtain as much client history/information as possible in the circumstances; from others if necessary. If possible administer the Impact of Events Scale (IES-R).

PHASE II: PREPARATION

Start with stabilization and resources such as a safe/calm place exercise, resource connection, and/or the 4 Elements exercise.

B

PHASES III and IV: EPISODE PROCESSING (multitarget processing)

These phases include assessment and processing of multiple targets identified from the event, experiences after the event, and the changing meaning of the original event.

1. Episode Narrative with Dual Attention Stimuli (DAS):

Episode narrative is running the movie of the episode while telling the story out loud with DAS (dual attention stimuli). This helps to ground and contain affect while the client begins the processing. Using a distancing metaphor, e.g., T.V. screen, gives additional containment if needed.

Say: “I am going to ask you to view the whole episode, from the beginning until today, as on T.V. Imagine that you are watching the episode on a screen with a remote control that can make the screen smaller, further away, lower the volume or even stop it—and tell the story out loud.”

Use continuous DAS during the episode narrative.

2. Episode “Google Search” (GS) with DAS:

Say: “Now, without talking out loud this time, return to scan the whole episode, like ‘Google Search’ in the computer, for any excessive disturbance, 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.”

Target each point of disturbance: (sensory images/events/other disturbing experiences).

(continued)

TABLE 3. (continued)

Option: If the target is an intrusive sensory image use the EMD protocol for desensitizing this image. It is usually a short procedure. Then return to GS for additional targets.

Process each target: Using as much of the standard protocol assessment as is appropriate (use clinical judgment): Image, NC, PC, VoC, Emotion, SUD, Body sensation.

Say: *Focus on the image, the words (NC.....), the feelings and body sensations.*"

Do a set of DAS.

After each set say: *"Take a deep breath. ...What do you get now?"*.....

I- If the association is about the episode:

Say: *"Go with that"* ... and continue with DAS, as with standard EMDR processing—as long as the association is related to the episode.

II- If the association is not related to the episode then return to focus on the target event.

Say: *"Go back to the target, what do you get now?"*.....

Continue the processing until the SUD drops to ecological level.

Goal of episode multitarget processing:

To integrate the disturbing images/events/other experiences within the episode so that processing can proceed.

Continue with the *"Episode Google Search"* to find other targets of disturbance and then process each one, as above.

Checking the episode SUD (E-SUD)

When no more targets emerge with GS check the **SUD for the entire episode.**

Say: *"When you think of the whole episode until today, how disturbing is it to you on a scale of 0 to 10?"*.....If it is not ecological, then check with GS for remaining pockets of disturbance to be processed. This may indicate a need for a higher meaning level of processing, addressing negative themes/world assumptions.

When SUD is ecological proceed to Installation of Episode PC.

C

PHASE V: INSTALLATION of EPISODE POSITIVE COGNITION (E-PC)

Say: *"When you look at the whole episode now, how would you like to think about it? What have you learned from it?"* (obtain a PC for the whole episode)

Check the VOC. Say: *"When you think of the whole episode until today and say the words (PC) how true does it feel to you on a scale of 1 to 7?"*.....

"Episode installation" with DAS

Say: *"Think of the PC and run the movie of the whole episode again starting from the beginning until today."*

Install with sets of DAS.

Goal of episode processing: To integrate the whole traumatic episode within a positive theme cluster, completing transition from external physical survival to adaptive internal identity theme.

D

PHASE VI: EPISODE BODY SCAN

Say: *"When you think of that episode and your positive cognition (state PC), notice what is going on in your body, if there is any body sensation, let me know."*

Use sets of DAS as in the standard protocol.

PHASE VII: CLOSURE

The protocol may take several sessions, so ensure a strong closure (return to safe/calm place, resource connection, and/or 4 Elements exercise).

PHASE VIII: FOLLOW-UP

Obtain feedback from previous work and check Episode SUD. If not ecological, use G-Search to identify any residual targets which may require additional processing.

If possible administer the Impact of Events Scale (IES-R) again.

The R-TEP (Table 3) incorporates the EMD and RE protocols within its overall unifying approach and expanding focus, making the *whole episode* (from the event until today) the strategic focus.

Main Features of the R-TEP

Stabilization. The R-TEP attempts to retain the structure of the eight phases of the standard EMDR protocol. In phase I, client history/information is obtained as much as possible in the circumstances and from others if necessary. Screening for complex PTSD is advised. In phase II (preparation), attention is given to stabilization, which is essential when working with recent trauma. Following the war experience, the safe/calm place exercise was sometimes difficult to achieve or insufficient, and additional stabilization methods were needed, such as the 4 Elements exercise for stress management (E. Shapiro, 2007). It comprises various self-soothing, stress management exercises for client use: Earth (grounding), Air (breathing), Water (producing saliva), and Fire (safe place and/or other resource imagery). They are presented in a package that can be easily remembered, together with a bracelet or sticker, which acts as an anchor or cue reminder for frequent practicing. While working with recent trauma in the protocol, additional containment measures are usually indicated, such as the option of using a distancing metaphor.

Focusing on the Episode. RE protocols focus on the parts of a single traumatic event, whereas the R-TEP focuses on a series of events or experiences, which comprise the entire episode. The episode concept is extended to include the consequences of the traumatic event/s until today. This perspective makes it a “two-pronged” protocol (past to present), as opposed to the RE, which could be described as an extended “one-pronged” (past focus) protocol.

Episode Narrative With DAS. The client is asked to run the “movie” of the episode while telling the story out loud during dual attention stimulus (DAS). DAS is employed (for grounding and present orientation) while the client is instructed both to “watch the movie” (for distancing) and to tell the story out loud. Apart from the importance of the narrative for assessment of the episode history, telling the story of the recent traumatic event seems to be more containing and also facilitates initial processing and integration (see the case of Sarah below). Prior to this the client is discouraged from going into detail about the event to avoid triggering high arousal prematurely.

The reason for the initial distancing and the unusual application of DAS during the relating of the story stems from clinical experience. In recent trauma processing the client is likely to exhibit very high SUD levels and be readily flooded. The therapist can therefore facilitate containment by maintaining at least partial attention to present safety by means of a distancing metaphor and grounding effects of the DAS.

“Google Search” (GS) Metaphor. The “Google Search” (GS) is a modified mechanism for target selection and a strategy for checking for residual disturbance. Clients are asked, without talking, to search their memory of the entire episode (not necessarily in a sequential way) for the parts that are still disturbing them. This contemporary metaphor for a “mental search engine” applied with the mechanics of DAS seems to deliver more appropriate targets for processing, which may not have been reported if asked for in the usual way. These targets can then be processed with the standard protocol (applied flexibly). The term “Google Search” was proposed playfully initially. However, it became apparent that this mechanism employs the same information processing “language” of EMDR, perhaps mimicking natural associative processes. The GS implies simultaneous scanning and categorizing, which are manifestations of the ability of the mind to differentiate and integrate in complex ways via its associative networks. GS can also be used in other ways, like “resource GS” for targeting resources, or “Googling back” (similar to “float back”), or “Googling forward” (future projection).

Regulation of Associative Chains. The option of limiting the associative chains to the image, event, or episode helps contain and regulate the processing according to the level at which it is stuck. The possibility of keeping the associations focused on the episode by frequently returning to the target when clients depart to other issues provides the therapist with a possible mechanism of containment. This is an extension of the idea in the EMD protocol of going back to target after each set. This regulation is regarded as a clinical choice point, in which the strategy is to focus more narrowly on the recent event and episode at first and only to widen the focus if this is not sufficient for releasing spontaneous processing. The regulation of associations corresponds with the idea of a narrow focus that gets wider as one moves from the processing of image to event/episode and then to theme. It is speculated that in recent traumatic

events/episodes the unprocessed associations are not yet integrated within a theme cluster. Therefore processing with R-TEP can prevent the traumatic episode from being integrated into a negative cluster. Processing with the R-TEP can be of benefit even after longer than three months, when thematic issues may be prominent, because the focused processing of the episode can weaken linkage to negative themes and strengthen links to positive theme clusters (see case of Dina below).

A Bridge From Episode to Theme. The transition from physical to psychological survival issues parallels the evolving layers of meaning from external to internal identity themes or world assumptions. Immediately following trauma, issues usually concern safety, control, and guilt (as a retroactive attempt to restore control). Later issues may involve responsibility (self-blame, inferiority). Eventually, adaptive processing results in positive themes such as accepting appropriate responsibility for past events, experiencing a sense of safety in the present, and having new choices in the future.

R-TEP processing consolidates fragmented unprocessed images, moments, and experiences within the episode that includes the event, experiences after the event, and the changing meaning of the event. In this perspective the R-TEP can be seen as a bridge between the episode and theme processing levels (see Figure 2).

Case Examples

SARAH: A CASE ILLUSTRATING THE ADVANTAGES OF EPISODE NARRATIVE WITH DAS

Sarah was a young woman whose 2-week-old baby had died 2 months previously of a heart attack. Although ordinarily well functioning, she seemed so easily flooded that she was even unable to find a safe place without crying immediately. It took two extra sessions to achieve preliminary stabilization.

Sarah was asked to “Google” for any resource that helped her feel calmer. She came up with a friend whose voice and words helped her most. After installing this as a resource she was more prepared to begin processing the trauma and was asked to tell the story by running the movie (distancing) while talking out loud with DAS.

The surprising thing was that she could tell the whole story in minute detail (for the first time she said) with appropriate affect; tearful with occasional brief heavy tears, but not overwhelmed as she had been when even attempting the safe place exercise. After about 30 minutes her face changed, the fear was gone, and she could look the therapist in the eye for the first time properly and was much calmer. Processing had taken place, although no specific targets were selected. She also arrived at a spontaneous positive cognition (PC) “I am confident we did everything we could.” Over the next few sessions, she went on to

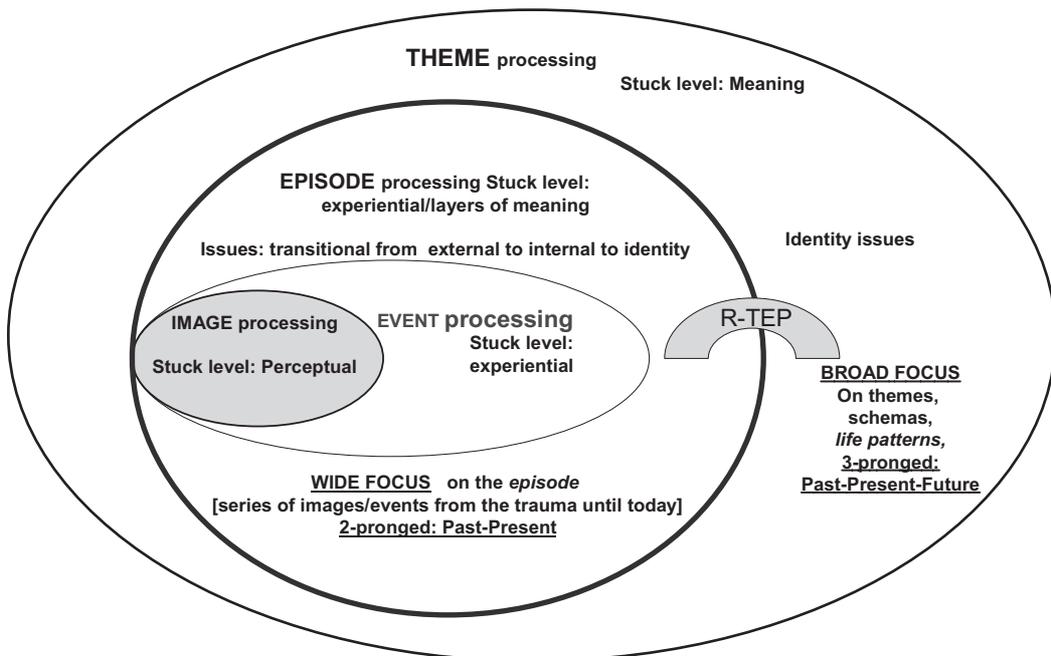


FIGURE 2. R-TEP (Recent Traumatic Episode protocol): Part/whole levels of processing and a bridge from episode to theme in early EMDR interventions (EEI).

successfully process selected targets from the episode using “Google Search.”

RON: A CASE ILLUSTRATING THE USE OF THE RECENT TRAUMATIC EPISODE PROTOCOL (R-TEP)

Ron was an entomologist on a field trip in Africa with friends. One night while he was sleeping alone in his tent he was suddenly awakened by a roaring lion close to his head. For 15 minutes he was certain he was going to die and thought his friends had already been eaten by the lion or lions, or that they had run away abandoning him. He experienced absolute terror (it is said a lion’s roar can be heard 5 miles away and has been described as “blood curdling”). Showing active resourcefulness, lighting his torch and shouting at the lion to go away, he eventually ventured out to see what had happened to his two friends. They were sleeping in the vehicle, and he joined them inside it. They were all unharmed.

Ron had some acute stress response symptoms for a few days. They went away gradually and he managed to finish his trip. After coming back, apart from some irritability, he did not seem to have any obvious symptoms until almost 3 months later when he started getting flashbacks, intrusive thoughts and images, and disturbed sleep. Quite agitated and worried that he was getting PTSD, he asked for help.

A brief intake revealed a person with strengths; the safe place and preparation phase went smoothly. Ron first gave the episode narrative (telling the story out loud with DAS), which was rather mechanical and emotionless. Then he proceeded with GS, searching the whole episode from the day it occurred until today, to identify anything that was still excessively disturbing. The first target he chose with GS was the image of the lion’s head drooling over him (which he imagined). Assessment: Image—the lion’s head drooling over him; NC (Negative Cognition) = “I am helpless, going to die”; PC (Positive Cognition) = “It was an adventure I survived, it’s over”; VOC (Validity of Cognition) = 2–3; Emotion = Fear; SUD = 8, Body sensation = in chest.

After only a few sets there was already a positive shift, which just got stronger and stronger. The lion shrunk and then receded and disappeared (image: perceptual level), with a tremendous body release, emptying and cleansing from his chest, ending up feeling light and relieved (sensation/affect: experiential level). The SUD reduced to 2, he felt empowered and able to see it as a story, an adventure belonging to the past (VOC = 6.5). “I overcame my fear of dying and rose above it. It became an adventure, a story

to tell my grandchildren, how I was nearly eaten by a lion but managed to overcome it and defeat the lion” (theme: meaning level).

During the processing he realized what probably had triggered the delayed symptoms: He was arranging the specimens he had collected chronologically and just got up to the day of the trauma.

At the next session Ron reported that the main symptoms had reduced substantially but that he was less focused than usual (e.g., he got on the wrong train twice). Follow-up on the work done the previous time, which he referred to as “a close call,” seemed much further away, with an SUD of 0–1.

Following the R-TEP procedure, GS was employed for any residual disturbance. He soon stopped this time at the *sound* of the lion’s roar and the sensation in his body. This was surprising because he had already worked on this moment previously, but then the focus was on the imagined image of the lion’s head and accompanying thoughts. This intrusive audio and somatic sensation had an SUD level of 7–8. Image processing was used here and the SUD dropped dramatically to 0, with additional somatic release after a few sets.

Had it not been for the GS strategy of checking for further disturbance this unprocessed fragment may have been missed. One would have thought that he had finished processing the experience because it had reached an ecologically reasonable SUD level. It indicates the importance of using the GS for further identification of targets for processing even when the SUD level is low.

In this vein there were yet more lessons to learn. Continuing with GS (according to the R-TEP protocol) for the entire episode, Ron next stopped at an incident that had occurred the following day, when the jeep was stuck in the mud for 7 hours trying to cross a stream. During this time he apparently experienced a mild anxiety attack. This event was fully processed with the basic protocol: Image = sitting in the back of the jeep, no air; NC = “I am helpless”; PC = “I can be patient and cope”; VOC = 3; Emotion = shame; SUD = 4–5; Body = chest. The processing revealed interesting connections to a theme: “I must never be helpless . . . I always have to be active in stressful situations . . . this is how my mother survived in Auschwitz, by active coping. . . losing control does not necessarily mean death”—which were noted but not pursued much further. As this was not part of our treatment “contract,” associations were limited here and he was instructed to return to the original target. This processing was a growth experience leading to a more philosophical perspective of flowing and trusting, coping with setbacks, and looking upon them as adventures. Further GS revealed no more disturbance. Episode SUD = 0. Episode PC: = “I can flow and

cope,” VOC = 6. Ron even began contemplating future trips to Africa.

DINA: A CASE ILLUSTRATING NEED FOR ADDRESSING THEMES OR MEANING LEVELS FOR COMPLETING EPISODE PROCESSING

Dina, a young woman, was standing at the bus stop on her way to work when two cars collided near her and one of them ran into her, throwing her into the air. She sustained moderate injuries requiring several operations. Several months after the accident, she received EMDR treatment for PTSD symptoms. She responded reasonably well to treatment, which enabled her to commence her university studies. However, various strange lingering symptoms were exacerbated after the Lebanon war, in which she was exposed to missiles falling near her home.

Her therapist processed these later events and then decided to check the previous work with a GS for residual disturbance despite this being 18 months after the original accident. She stopped very soon and identified a disturbing thought: “On my way to the bus stop that morning I didn’t know that in 5 minutes something would happen which was going to change my life, what kind of world is this!” This world assumption belief was targeted and processed. She came to a resolution acknowledging her vulnerability but also that she was not helpless and had coping strengths. Continuing with GS, revisiting the accident and subsequent experiences of the episode (up to the present) revealed further targets for processing that were not previously identified.

Discussion

The Role of Attention Regulation

During a traumatic experience, our information absorption and processing system may be flooded by a chaos of threatening stimuli, triggering alarm. The emergency response imperative may monopolize attention. The emotional brain has the attention default. However, this can become maladaptive when hyperaroused, and selective attention becomes captured and/or dysregulated. Overloaded, our perceptual sensory system may *block or lock* the incoming information: Overwhelmed attention mechanisms either block access to the threatening information (denial, dissociation) or zoom into some conspicuous aspects and lock onto them obsessively (repetition, intrusive symptoms), becoming stuck rigidly in a time warp.

Aspects of the orienting response feature prominently among the various theoretical explanations for the underlying basis of EMDR treatment effects (F. Shapiro, 2001). The orienting response involves directing attention to a new stimulus. One of its functions may be to facilitate reality testing. The DAS in EMDR with “one foot in the present” (external reality) and “one foot in the past” (internal recollection of the traumatic event) (F. Shapiro, 2001, p. 325) may free attention from preoccupation with the (implicit) memory of past danger to enable the recovery of flexible, adaptive attention regulation.

Recent research has shown that the parts of the brain involved in attention regulation may be identical to the parts involved with eye movements (Corbetta et al., 1998; Moore & Armstrong, 2003; Pierrot-Desseilligny, Milea, & Muri, 2004). These fascinating findings are of particular interest for EMDR and should be explored further, suggesting as they do relevance to mechanisms occurring in EMDR. From the attention perspective, the R-TEP can also be viewed as a strategy for restoring adaptive attention regulation and appropriate reality testing.

Theoretical Speculations

Reflecting on theoretical aspects of the R-TEP suggests a possible organizational principle of the AIP model (F. Shapiro, 2001), which aims toward integration. It is manifested in two aspects, which work together. One is the capacity of the brain to integrate part/whole relations in hierarchical order (for example, sensory image → event → episode → theme → identity). Accordingly, information transmitted via the four modalities (sensory, emotional, somatic, and cognitive) is processed at increasing levels of complexity, from a simple processing level (perceptual), to a complex one (experiential), to a more complex one (meaning), perhaps matching the evolution of the brain. This also appears to correspond with the transition from implicit memory to explicit memory (F. Shapiro, 2006; Stickgold, 2002).

The second aspect of the organizing principle is the capacity to integrate opposites (parts) into a new whole via a dialectical movement (Laub & Weiner, 2008). In adaptive processing there is a dialectical movement between problems (negative associative chains) and resources (positive associative chains) during processing (Laub, 2001; Laub & Weiner, 2008). Perhaps the dialectical movement is the primary vehicle by means of which part/whole components of information are processed in an adaptive way. It is interesting to consider dual attention from this perspective.

Tentative Hypotheses Concerning the AIP Model

The AIP system moves toward completion. Completion means the containment of negative and positive experiences into an adaptive and harmonious whole. An organizing principle of the AIP system is manifested in the capacity to form hierarchical part/whole relations by differentiation and integration processes directed toward completion.

The part-whole components of information processing that we address in our model are: the sensory image → event → episode → theme → identity. Many sensory images are organized into one event. Many events are organized into one episode. Many episodes are organized into one theme. Many themes are organized into identity.

The processing of different “parts” facilitated by the dialectical movement between negative and positive associative chains leads to adaptive completion. When a “part” is stuck, the AIP is disrupted and cannot move toward the next “whole,” thus failing to reach completion. For example, intrusive, unprocessed images can disrupt the completion of the adaptive processing of an event. An unprocessed event/episode can disrupt the completion of the adaptive processing of a theme.

The AIP can be disrupted by blocking or locking the attention regulation that is needed for adaptive processing. Both blocking and locking obstruct the AIP from moving, either by blocking access to the information or by locking repetitively onto a part.

In PTSD, AIP is disrupted and fails to restore itself because there is chronic linking of associative chains to negative stored memories and a lack of linking to positive stored memories. The dialectical movement is therefore blocked. Successful processing of recent trauma can facilitate the AIP to restore itself (which usually happens spontaneously). It is possible that recent trauma processing with clients who were at risk for PTSD may reduce the possibility of linking the traumatic memory to similar negative stored memories, thus preventing PTSD development. In recent trauma processing, regulating the associative chains by limiting them to episode-related associations may be sufficient for adaptive processing since the trauma is not yet integrated into clusters of themes.

Following the model, it is insightful to briefly note some things about the standard protocol as the master integrator. The standard protocol relates to the various part-whole elements: the theme, the event, the most disturbing image, many events (episodes), which

unfold associatively during processing, according to a hidden order of a theme. The standard protocol attends to the perceptual, experiential, and meaning levels of information, which consist of the four modalities: sensory, emotional, somatic, and cognitive (thoughts and later beliefs).

Although the four modalities are present simultaneously at each level (perceptual, experiential, and meaning), one or two modalities are more salient: sensory at the perceptual level (image), emotional and somatic at the experiential level (event/episode), and cognitive at the meaning level (theme/identity). This is a further example of the hierarchical order of the organizing principle.

In summary, following trauma, multidimensional traumatic information (four modalities) in unorganized part-whole relations enters the brain to be processed. This information may be stored negatively (dysfunctionally) by being associatively connected to previous negative stored memories organized in negative theme clusters. The goal of the AIP system is to move the traumatic information, through differentiation and integration processes, to connect associatively with positive (functional) stored memories (the dialectical movement) in order to reach completion. Completion is manifested by associative chains of multidimensional adaptive information in well-organized part-whole relations where the negative information is embedded and contained in positive (adaptive) memory networks. The ultimate completion is momentarily experienced as a pure here and now sense of wholeness.

Conclusion and Suggestions for Further Study

The R-TEP incorporates the wisdom of existing protocols (EMD, RE, and the standard protocol) in a modified form with some new aspects.

Professional Concerns About Premature Intervention

Concerns about premature intervention are adequately addressed in this protocol by following the familiar, good practice, eight-phase structure similar to the standard protocol. Additional procedural elements of the R-TEP are designed to promote safety and confidence for the clinician and client. For example, the episode narrative with DAS, with its grounding of safety in the present and the option of regulating associative chains during processing (choosing to focus only on the image or event

or episode) and not necessarily opening up other clinical issues, provides additional ways of containing. The systematic and comprehensive structure of the R-TEP protocol makes it easier for a clinician to consider early EMDR intervention. Common sense suggests that intervention in the days and weeks after a critical incident should mostly be appropriate when there are unusual responses (excessive), delay or apparent failure to recover, and chronic sleep disturbances. The effectiveness of such interventions needs to be empirically tested. However, the bolder prospect of utilizing R-TEP as a convenient prophylactic screening procedure, as a means of checking for and enhancing adaptive processing following significant traumatic experiences, is a further possibility that remains to be investigated.

Thinking in Terms of the Episode

The episode is conceptualized as the period from the trauma to the present, requiring processing and integration, which has a beginning, a middle, but no end yet. One can think of it as a two-pronged protocol addressing recent past to present. The cases of Ron and Dina suggest that processing trauma by focusing only on the event itself using EMD or RE protocols may not necessarily be sufficient and that adopting a wider *episode* focus with a scanning strategy to seek out additional targets of unprocessed disturbance may be advised. This can be tested by re-evaluating subjects treated with EMD or RE, using GS to reveal the existence of any unfinished processing of the *episode*.

GS With DAS

GS is a mechanism suggested for *identifying* unresolved fragments of the traumatic episode for processing. Clinical observation suggests that it may have advantages for revealing targets for processing, which may not have been reported if asked for in the usual way, and also as a means of checking more thoroughly for remaining pockets of disturbance. However, this needs to be studied and tested.

Widening Focus and Level of Trauma Processing

Although this article is primarily concerned with early intervention, it may be more useful in practice to think in terms of the level at which the processing

is stuck rather than in terms of the time that has passed. In a way all current disturbances relating to past, type I, single incident, and life-changing traumatic experiences, could be described as “unfinished” traumatic episodes, with the memory stuck at the implicit memory state. Therefore this protocol could possibly be applied to nonrecent traumatic episodes as well. The role of time after the event needs to be investigated: At what point can it still be called a recent event? How is it differentiated from a nonrecent event? Perhaps a distinction can be made between *processing* (recent event) as opposed to *reprocessing* (nonrecent event)?

Further study is needed to confirm the face-valid speculations about the widening focus of trauma processing and levels at which it can become stuck. In this view the focus of the processing starts from an orienting sensory reception of threatening information (perceptual level), expands to an emotional and somatic survival response (experiential level), and proceeds to a broad cognitive focus on the life pattern themes of identity and world assumptions (meaning level).

Prevention of PTSD

The exciting prospect that early EMDR interventions, such as the R-TEP, may contribute to the prevention of the development of PTSD is an important subject for further research.

Summary

The R-TEP evolved from an urgent need in the field, clinical experience, and new conceptualizations concerning memory consolidation following recent trauma. Three main issues were identified concerning EEI after a critical traumatic incident: the nature of the fragmented memory, the nature of the stressful situation for client and therapist, and the nature of the therapy contract. Existing EEI protocols only gave partial answers to these issues. The R-TEP was therefore developed to provide a more systematic and comprehensive approach to EEI, which incorporates and extends the existing procedures within an adapted eight-phase structure borrowed from the standard protocol. It bridges the gaps left by these previous protocols, facilitating a transition from the RE to the standard protocols.

Theoretical speculations were made relating to the Adaptive Information Processing (AIP) model as well as the possible role of attention regulation.

The R-TEP attempts to offer a clear and comprehensive protocol for the first aid tool box of the EMDR practitioner, which will assist in addressing all three of the above issues so that the prospect of EEI may be approached with more confidence.

The ideas expressed in this article are still tentative and developing and await further research. It is important to study the effectiveness and applications of the R-TEP, its implications for preventing PTSD, and the suggested theoretical model.

It is hoped that it will stimulate discussion and further interest in this area. Comments and feedback from the reader's experience with this protocol are welcomed.

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