

# **The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI)**

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This protocol is based on Dr. Shapiro's (2001) Recent Traumatic Events Protocol and the observations of Ignacio Jarero and Lucina Artigas during their many years of experience working in the field with natural or human provoked disasters survivors in Latin-America and the Caribbean.

## **The EMDR Protocol for Recent Critical Incidents Script Notes**

The EMDR-PRECI departs from the Recent Traumatic Events Protocol in response to the authors' observations in the field with survivors of man-made and natural disasters. The following changes are explained below and annotated in the script.

(1) The clinician asks the client to describe the event in a narrative *form from right before the event occurred until the present moment*. The EMDR-PRECI is often used with disaster survivors six months after the event. Through Jarero and Artigas' experience working with groups of disaster survivors in Latin-America and the Caribbean, they observed that these groups seemed to have different economic, socio-cultural experiences and government structures compared to the U.S. or Europe. They found that in these groups, the impact and the memories (even 6 months later) behaved as if they were unconsolidated recent traumatic events 2-3 months old or less. For example, concentrating on /reprocessing one part of the memory had no effect on any other part of the incident. Jarero and Artigas hypothesized that this is because a disaster is a continuum of important markers: pre-impact, impact, heroic phase, honeymoon phase, disillusionment phase, anniversaries, and reconstruction phase (Everly and Mitchell, 2008). Perhaps, the state dependent nature of the traumatic memory (van der Kolk & van der Hart, 1991) and the continuum of stressful events with the similar emotions and physical sensations do not give the memory sufficient time to consolidate into an integrated whole. Thus, the memory network is in a permanent excitatory state and growing with each event in this continuum. There has been no definitive research to measure the consolidation process or to determine individual variables that may influence

consolidation. It appears that the time for memory consolidation may vary considerably (Maxfield, 2008).

Jarero & Artigas also observed that when they asked clients to recite the history of the event, they actually described the event in a narrative form from just before the impact until the present moment (even 6 months later). For them, there is not a day or exact moment in which the original event memory finished and new stressful events began. It behaves as a continuum often along the themes of safety, responsibility and choice (e.g. what they were doing right before the earthquake; when the earthquake struck; what happened when the tsunami occurred; feelings of being unsafe; how people treated each other after the event that were upsetting such as issues of being attacked, raped or others harmed; things they felt they should have been able to prevent and could not; issues of loss; medical issues; concerns about the food and water contamination; how they are effected currently; the economic issues in the present and future, etc.). These observations are similar to Elan Shapiro and Brurit Laub's (2008) *Recent Traumatic Episode* conceptualization that recommends targeting the original incident along with any significant subsequent experiences until the present.

(2) The clinician does *not* ask or probe for the most disturbing aspect of the event. This recommendation is to avoid triggering abreactions before containment and safety measures are in place and treatment processing can begin.

(3) The clinician does not do BLS during Phase 1 Narrative. This recommendation is made as a safety measure for the client because bilateral stimulation -in accordance with the AIP model- activates the brain's adaptive information processing system, allowing information from other neural networks to link in (Solomon & Shapiro, 2008). Therefore,

at this stage of the protocol, BLS could elicit dysfunctional information before containment and safety measures are in place.

(4) When possible, administer a scale during Phase 1, before reprocessing, to have a baseline measure when the client first comes for treatment and post-treatment to assess effectiveness. This suggestion is in order to answer Francine Shapiro's call to conduct randomized research that will support the empirical validation needed to reach even more of the world's victims of disasters and to help them relieve their suffering (Luber & Shapiro, 2009).

(5) The Butterfly Hug originated by Artigas is a self-administrated bilateral stimulation method for an individual or for group work (Artigas et al., 2000; Boel, 1999). It can be used during the EMDR-PRECI to facilitate reprocessing. It is thought that the control obtained by clients over their self-use of BLS, may be an empowering factor that aids in their experience of a sense of continuing safety while processing traumatic memories. Patients can be instructed to use this method between sessions when a disturbing affect suddenly arises (trigger, flashback, nightmare, etc.) and the self-soothing techniques seems not be effective.

(6) Frequently after a disaster it is difficult for the client to achieve a Safe/Calm Place so the following self-soothing strategies are easy to teach and learn and have high efficacy: Abdominal Breathing, Concentration Exercise and Pleasant Memory Technique.

(7) The clinician says: "*Mentally run the movie of the whole event from right before the beginning until today and at the end please let me know the worst part.*"

This instruction allows the identification of the worst part of the event that then becomes the first target for reprocessing, once the client has containment and safety measures in place.

8) During the Assessment Phase, the clinician waits for clients to respond with their own NC before offering one such as “I’m in danger,” if clients are unable to come up with their own cognitions. Also, it is helpful not to ask clients for a PC or VoC for the fragment because -due to the continuum of stressful events- it makes it very difficult for them to find a PC for each fragment and this may increase their sense of failure therefore adding more stress. Once the target is activated, desensitization is commenced (Phase 4) until SUD=0 or is ecologically appropriate. Additional fragments are then elicited and desensitized until all disturbing fragments are desensitized. Since Phase 5 is not included here, working with the Extended Installation Phase is not begun until all the separated aspects of the event or fragments are completely desensitized (Phases 3 & 4).

(9) Target and reprocess only Phases 3-4. After eliciting the Assessment for the fragment, in the Desensitization phase, desensitize each separate aspect of the event and do not include the Installation Phase (5) for the reasons stated in the previous explanation.

(10) Ask the client to visualize the entire sequence of the event again with eyes closed and reprocess *only fragments with disturbance*. Suggesting chronological order is simply a way to ensure that everything is processed. Depending on the circumstances (such as if there are many fragments for each client, many people and few clinicians), the clinician can ask the client to visualize the entire sequence of the event with eyes closed and reprocess only fragments with disturbance.

(11) The sentence, “*And let whatever happens, happen*” avoids the possibility that traumatized clients misunderstand the instruction and try to hold in mind the PC during the BLS sets, resulting in obstructed reprocessing.

(12) Over a number of years, it has been observed that the majority of survivors do not reprocess most of the traumatic material during Phase 4 and, there is the same amount of maladaptive material in Phases 5 and 6, e.g. there is not a sufficient amount of processing after each set to decrease the maladaptive material. Perhaps, this is due to the continuum of stressful events, the state dependent nature of the traumatic memory and/or the continuing state of difficulty for the population/city/country, in general, resulting in many ongoing triggers (people living in tents; difficulty with food supply; many injured people, etc.). Despite the reason, it is important that this material be addressed and reprocessed. As a result, we do not assess the VoC after each set as is the way it is done in the Recent Traumatic Event Protocol (F. Shapiro) because it is clear that the material is not a block but the nature of how the memories are held and processed in this population.

The following instructions were written down to remind clinicians to use them while working in the field after a disaster as they may be tired, hungry, thirsty, overwhelmed by the terrible narratives and/or finding it difficult to concentrate.

A) At the end of the set say: “*Take a breath...what do you notice now?*”

B) If disturbing material arises say, “*Go with that*” or “*Notice that.*”

C) Continue BLS as long as the information is processing.

(13) Shapiro’s rationale for the Phase 5 Supplement Step is that if clients hold their PC in their minds during the closed eyes review of the whole sequence (different than

reprocessing during BLS), it is easier for them to feel if the PC is less true during any part of the sequence. The clinician then targets that part.

## **The EMDR Protocol for Recent Critical Incidents**

### **(EMDR-PRECI) Script.**

Phase 1: Client History.

The numbers in parentheses show the rationale for the steps within the EMDR-PRECI Protocol and are explained following the script.

The clinician asks the client to describe the event in a narrative form from right before the event occurred until the present moment (1).

If the client is in great distress (e.g. crying and not able to speak) or has physical complaints (e.g. headache, dizziness, nausea, etc.) do not push for the narrative.

Say, *“Just give me a brief description of what happened.”*

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Identify a series of separated aspects of the event (fragments).

Say, *“Without details, please tell me about the different aspects of what happened to you that are standing out for you.”*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Note: Do not ask or probe for the most disturbing aspects of the event (2) or do BLS during this phase (3).

When possible administer a scale (e.g. IES, IES-R) pre-reprocessing to have baseline measure and post-treatment to assess effectiveness (4).

## Phase 2: Preparation.

Screen the client to make sure appropriate candidate for EMDR.

Does the client exhibit:

Life-threatening substance abuse	_____	YES	_____	NO
Serious suicide attempts:	_____	YES	_____	NO
Self-mutilation:	_____	YES	_____	NO
Serious assaultive behavior:	_____	YES	_____	NO

Educate the client about EMDR.

Say, “*“When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations. EMDR seems to stimulate the information and allows the brain to reprocess the experience. That may be what is happening in REM or dream sleep. The eye movements (tones, tactile, Butterfly Hug) may help to process the unconscious material. It is your own brain that will be doing the healing and you are the one in control.”*”

Instruct the client in the mechanics of EMDR, also including the Butterfly Hug (5).

Say, “*“Cross your arms over your chest, so that the middle finger from each hand will be placed below the collarbone and the rest of the fingers and hand will cover the area that is located under the connection between the collarbone and the shoulder and the collarbone and sternum or breastbone. Hands and fingers must be as vertical as possible (fingers toward the neck and not toward the arms). Once you do this you can interlock your thumbs (forming the body of the butterfly) and the extension of your other fingers*”

*outward will form the butterfly's wings. Your eyes can be closed or partially closed looking toward the tip of your nose. Next you alternate the movement of your hands, simulating the flapping wings of a butterfly. You breathe slowly and deeply (abdominal breathing), while you observe what is going through your mind and body (cognitions, images, sounds, odors, affect and physical sensations) without changing, repressing or judging. You can pretend as though what you are observing is like clouds passing by (for the Butterfly Hug scripted protocol, see Artigas & Jarero, 2009).*

Teach the client self-soothing strategies such as Abdominal Breathing, Concentration Exercise and/or and the Pleasant Memory Technique. (6)

### **Abdominal Breathing.**

*Say, "Close your eyes put one hand on your stomach and imagine that you have a balloon inside your stomach. Now, inhale and see how the balloon grows and moves your hand up. Now you can exhale and see how the balloon deflates, and, your hand goes down. Put all your attention in that. If anything distracts you gently return to the exercise"*

Do this exercise for 5 minutes.

### **Concentration Exercise.**

*Say, "While doing the abdominal breathing mentally repeat: I know I'm inhaling...I know I'm exhaling. Put all your attention in that. If anything distracts you, gently return to the exercise."*

Do this exercise for 5 minutes.

## Pleasant Memory.

Say, *“Remember a time when you were calm or happy...put your hand in your chest...expand those good feelings and physical sensations in your body. Put all your attention on that. If anything distracts you gently return to the exercise”*.

Do this exercise for 5 minutes.

## Phase 3: Assessment.

Run the movie to establish the first target.

Say, *“Mentally run the movie of the whole event from right before the beginning until today and at the end please let me know the worst part, the worst fragment.”* (7)

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Access the Image, Negative Cognition, Emotion, SUDs, and location of physical sensation (8) and processed in the order indicated below:

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*Picture.*

Say, *“What picture represents the disturbing aspect or moment of the event?”*

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If there are many choices or if the client becomes confused, the clinician assists by asking the following:



*Location of Body Sensation.*

Say, *“Where do you feel it (the disturbance) in your body?”*

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#### Phase 4: Reprocessing Sequence.

Target and Reprocess (9) in the Following Sequence:

- a. Elicit worst fragment (see above)
- b. Elicit other fragments.

Ask the client to visualize the entire sequence of the event again with eyes closed and reprocess *only fragments with disturbance.*

Say: *“Mentally run the movie of the whole event from right before the beginning until today and at the end please let me know any other part that disturbs you now.”* (10)

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*Picture.*

Say, *“What picture represents the disturbing aspect or moment of the event?”*

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If there are many choices or if the client becomes confused, the clinician assists by asking the following:

Say, *“What picture represents the most traumatic moment of the event?”*

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## Run the Movie.

Have the client visualize the entire sequence with eyes closed and reprocess it as any disturbance arises. The client should have a full association with the material as it is being reprocessed. If there is disturbance, the client should stop and inform the clinician. Repeat until the entire event can be visualized from start to finish without emotional, cognitive, or somatic distress.

Say, *“Please visualize the entire sequence of the event with eyes closed. If there is any disturbance, please open your eyes and we will reprocess the material together.”*

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Repeat this until the client can visualize the entire event from start to finish without distress.

## Phase 5: Global Installation Phase.

Elicit the representative Positive Cognition of the entire event.

Say, *“When you bring up the event, what would you like to believe about yourself now?”*

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Check the VoC.

Say, *“When you think of the event, how true do those words \_\_\_\_\_ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”*

1            2            3            4            5            6            7

(completely false)

(completely true)

Link the PC and the entire event and add BLS.

Say, *“Think of the entire event (or incident) and hold it together with the words\_\_\_\_\_ (repeat the selected positive cognition), and let whatever happens, happen.”* (11)

Do sets of BLS (same speed and approximate duration as in Desensitization) to fully install the PC (VOC=7).

At the end of the set say, *“Take a breath...what do you notice now?”* (12)

If disturbing material arises say, *“Go with that or Notice that.”*

Keep doing BLS while information is moving.

When BLS stops, check VoC until the PC is fully installed (VOC=7).

Say, *“When you think of the event, how true do those words\_\_\_\_\_ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”*

1        2        3        4        5        6        7

(completely false)

(completely true)

If VoC < 7, check for a Blocking Belief.

Say, *“What prevents this from being a 7?”*

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Reprocess with BLS whatever client reports until VoC=7.

### Supplemental Step.

Say, *“Close your eyes, think of the positive cognition, and review the whole sequence in your mind as you are holding the PC.”*

On completion, say, *“Does the positive cognition feel less than true on any part of the sequence?”*

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If so, target that part (Shapiro, 2010 personal communication) (13).

### Phase 6: Body Scan.

Run a Body Scan following standard procedures.

Say, *“Close your eyes and keep in mind the event and the (repeat the positive cognition). Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find tension, tightness, or unusual sensation, tell me.”*

### Phase 7: Closure.

Use the standard procedures to close the session.

Say, *“We are almost out of time and we will need to stop soon. You have done some very good work and I appreciate the effort you have made. How are you feeling?”*

*Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations or dreams. Please make a note of whatever you*

*notice. We will talk about that at our next session. Remember to use one of the self-control techniques as needed.”*

### Three- Pronged Approach.

1. Past memories were the traumatic incident memories already reprocessed.
2. Reprocess present triggers with the client. Each trigger may be connected to different situations that need different skills sets or information to optimize future functioning. A Future Template is done for each trigger that is processed.

Process *present stimuli* that may cause a startle response, nightmares, and other reminders of the event that the client still finds disturbing, if necessary.

#### *Target or Memory—Startle Response*

Say, “*Are you having any startle responses to situations, events, or stimuli that are related to this event?*”

#### List for Situations and Events that Trigger the Incident.

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#### *Picture.*

Say, “*What picture represents the disturbing aspect or moment of the event?*”

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Say, *“Where do you feel it (the disturbance) in your body?”*

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Continue with Phases 4 through 7 for the situation, event, or stimulus that triggers you from above and any others. After processing the first triggered situation, check to see if any of the others mentioned are still active; if not, proceed to the next question. If there are more startle responses that need to be processed, go ahead and reprocess that experience.

### Future Template.

Clinician asks the client to run movie for the desired response to cope in the future.

Say, *“This time, I’d like you to close your eyes and play a movie, imagining yourself coping effectively with \_\_\_\_\_ (state where client will be) in the future. With the new positive belief \_\_\_\_\_ (state positive belief) and your new sense of \_\_\_\_\_ (strength, clarity, confidence, calm), imagine stepping into the future. Imagine yourself coping with ANY challenges that come your way. Make sure that this movie has a beginning, middle, and end. Notice what you are seeing, thinking, feeling, and experiencing in your body. Let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don’t hit any blocks, let me know when you have viewed the whole movie.”*

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If the client hits blocks, address as above with BLS until the disturbance dissipates.

Say, *“Go with that.”*

Jarero & Artigas suggest that the EMDR-PRECI must be part of a community based trauma response program that provides a continuum of care for the treatment and management of individual and group reactions to shared traumatic events. This continuum of care must be accessible to the community members and sensitive to each participant's gender, developmental stage, ethno-cultural background, and magnitude of trauma exposure (Macy et al., 2004).

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