

College Counseling Case Studies

Using Recent Traumatic Episode Protocol in College Counseling Centers

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Experiencing a traumatic event as a college student can have significant social, emotional, and academic consequences. This article discusses the use of an alternative protocol of eye-movement desensitization and reprocessing, called Recent Traumatic Episode Protocol (E. Shapiro & Laub, 2008), and its use to reduce significant psychological distress of a college student who lived through a mass casualty shooting in the United States.

Keywords: Recent Traumatic Episode Protocol, college students, trauma, EMDR, gun violence

College can be a stressful time for individuals, and mental health disorders are becoming more frequent and prevalent among the college population (Auerbach et al., 2016; Beiter et al., 2015). The demand for mental health services continues to rise on college campuses (Xiao et al., 2017) and the issues have become more severe (Center for Collegiate Mental Health, 2018); these realities may suggest college counseling centers need to look at treating their students differently. Over the last several years, research has established that eye-movement desensitization and reprocessing (EMDR) is effective in treating more than just war-related traumas.

Two decades ago, Enright, Baldo, and Wykes (2000) studied the use of EMDR to treat test anxiety and concluded that two sessions of EMDR treatment had significantly lowered total test anxiety scores. More recently, Aslani, Miratashi, and Aslani (2014) suggested EMDR had a significant impact on public speaking anxiety and confidence levels of college students. Despite these studies, there has been a lack of research using EMDR within college counseling centers. This article illustrates a case study exploring how counselors working in college counseling centers may use EMDR and several specialty EMDR protocols such as Recent Traumatic Episode Protocol (R-TEP; E. Shapiro & Laub, 2008).

EMDR and R-TEP

EMDR assists in the resolution of past traumas and can help college students overcome the associated psychological distresses. Researchers have demonstrated that individuals who have experienced traumas have been treated with cognitive

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behavior therapy (Kar, 2011; Tol, Barbui, & Van Ommeren, 2013), dialectical behavior therapy (Landes, Garovoy, & Burkman, 2013; Ritschel, Lim, & Stewart, 2015), psychodynamic therapy (Roberts, Kitchiner, & Kenardy, 2010), art therapy (Schouten, Niet, Knipscheer, Kleber, & Hutschemaekers, 2014), and medications. Medications have been a long-standing recommendation for individuals who have posttraumatic stress disorder (PTSD; Sareen, 2014).

The Veterans Health Administration and Department of Defense endorse the use of exposure therapy as another means to treat PTSD (Watkins, Sprang, & Rothbaum, 2018). Some scholars have questioned the uniqueness of EMDR, suggesting it is a form of exposure therapy rather than a stand-alone model. Researchers have questioned the use of eye movements as a contributing component to the results obtained using EMDR (Davidson & Parker, 2001; Nevid, Rathus, & Greene, 2014), suggesting it is the reexposure to the trauma rather than the eye movements that allow desensitization. Although there remain many questions concerning how EMDR works, researchers have established eye movements as an essential component of the EMDR process (Jeffries & Davis, 2012; Lee & Cuijpers, 2013). These researchers have provided support for the use of eye movements as unique components of EMDR that directly contribute to the positive outcomes. It is the positive results that continue to make EMDR a useful approach to use with individuals.

Various EMDR protocols offer alternative approaches to processing an emotional attachment to a trauma. Francine Shapiro's EMDR protocol for recent traumatic events was a result of working with survivors of the 1989 San Francisco Bay Area earthquake (F. Shapiro, 2001). She discovered that when survivors tried to focus on the event, it was too overwhelming and challenging for them to reprocess. The survivors found several smaller traumas within the larger trauma that continued to interrupt their reprocessing, and thus, she developed a protocol for recent traumatic events. Although Francine Shapiro's Recent Event Protocol proved successful as a treatment for trauma, Elan Shapiro and Brurit Laub created a more comprehensive protocol (E. Shapiro & Laub, 2008). This protocol, R-TEP, is recommended for use in situations in which trauma has occurred within the last 90 days; however, it is not limited to this time frame and may be used with earlier traumatic events as well (E. Shapiro & Laub, 2008). Research has suggested that early treatment of traumatic experiences can prevent the solidification of the detrimental connections often associated with PTSD (F. Shapiro, 2001).

The R-TEP procedure (E. Shapiro & Laub, 2008) has eight phases, and there is not a predetermined expectation for how many sessions each phase should comprise; rather, the protocol is dependent on the rapport and movement of the client, much like any other form of therapy. Phase 1 is the rapport-building stage, wherein the client's history is obtained and education in EMDR/R-TEP, informed consent, and the assessment for appropriateness are performed. Phase 2 is the preparation of the individual for treatment. This phase includes providing information regarding bilateral stimulation (BLS) mechanics and procedures and reprocessing aids, and developing stress reduction activities. Phase 3 is the assessment stage wherein the individual accesses the target memory and processes the

memory as it exists in the present moment. Using BLS, the individual is asked to tell a narrative of the event. Once the narrative is obtained, the individual is asked to perform an internal mental search for specific situations within the event that cause distress naturally. The distressing instances are referred to as *Points of Distress* (PoDs). The baseline measurements for the image, Negative Cognition, Positive Cognition, Validity of Cognition (VOC), and Subjective Units of Distress (SUD) are obtained for each PoD.

Phase 4 is when desensitization occurs, beginning with the PoD with the highest SUD score and progressing through the remaining PoDs in chronological order. The goal of this stage is to reduce the SUD and increase the VOC to ecological values for each PoD. Once this has been achieved, the individual proceeds to Phase 5. During this stage, the Episode Positive Cognition (E-PC) is determined, an ecological VOC score is obtained, and the stage is complete when the individual can visualize the entire event without any individual PoD challenging the individual's VOC of the E-PC. During Phase 6, the client completes a full body scan, seeking any residual sensations associated with the trauma that do not support their E-PC. Phase 7, the closure phase, can be initiated at any time during the process. This stage ensures the individual is stable after the R-TEP session and can maintain stability between sessions. An individual PoD may not be completed in one session, and it is important to acknowledge that the reprocessing can continue after the session and if the individual becomes distressed to contact the counselor before their next appointment. The final component of the R-TEP procedure is Phase 8, where feedback and a brief assessment of any symptoms occurring since the previous session are obtained. Once the R-TEP protocol has been completed a follow-up is encouraged to establish the client continues to maintain the positive outcomes of the process.

The case study presented in the next section illustrates the R-TEP method and how it was used in a college counseling center.

Case Study

Corey

EMDR is a modality of therapy that requires training. The training consists of two 3-day training seminars, 20 hours of supervised practicum, and 10 hours of consultation. An additional 20 hours of consultation and the utilization of EMDR with at least 25 separate individuals are required to become a clinician who is certified in EMDR by the EMDR International Association (EMDRIA). Certification is not required to practice EMDR. There are many trainings held across the country that are hosted by the EMDR Institute and Trauma Recovery: EMDR Humanitarian Assistance Programs (HAP). Both organizations are endorsed as training organizations by EMDRIA. I had completed both 3-day training sessions at the time of this case study and was in the process of obtaining my additional consultation and session requirements to become an EMDRIA-certified EMDR clinician. Before and during

the R-TEP protocol, I sought consultation with an EMDRIA-certified EMDR consultant who had been practicing EMDR for over 15 years.

Before Corey's (pseudonym) case, I had used only the standard EMDR protocol developed by Francine Shapiro. The standard protocol was used with clients experiencing family-of-origin issues, sexual abuse, rape, a car accident, and anxiety-related concerns. In all previous cases, the trauma had happened more than a year before the client started EMDR therapy. When Corey came in for counseling, I saw the opportunity to help him through R-TEP because he sought counseling within 2 weeks of experiencing major trauma.

Corey's presenting issue was panic attacks while trying to fall asleep. During Corey's initial appointment, he reported excessive and uncontrollable worrying and intense anxiety in public situations, which resulted in the avoidance of classrooms, grocery stores, and places with large crowds. He denied suicidal thoughts and self-injurious behaviors. Corey reported that his anxiety began after he attended a music festival where a mass casualty shooting occurred. He presented because his issues were getting worse, and the symptoms were interfering with his schooling.

Phase 1 (Rapport Building)

I focused on building rapport and allowed Corey to talk about his struggles. He spoke of the incident that left him feeling unsafe, paranoid, and vulnerable at night while trying to fall asleep. His sleep was interrupted by nightmares revolving around his running from the sound of gunfire. He spoke of flashbacks and intrusive thoughts occurring at all points during the day. He had constant feelings of being unsafe, was unable to concentrate, and experienced flashbacks triggered mostly by sounds in his environment. The feelings of being unsafe infiltrated every aspect of his life. He did not feel safe in classrooms and was hyperaware of his surroundings. This experience was overwhelming and led Corey to isolate himself often. The decrease in his perception of his safety progressed into what he referred to as paranoid thoughts.

He explained that some of the paranoid thoughts had developed into conspiracy theory beliefs; his inability to control his fears contributed to a decrease in socialization and enjoyment in his life. Corey was an avid hunter and spoke positively about a recent hunting experience; however, he had an adverse experience when he and his friends went to a gun range. Corey stated that the sound of the gunfire sent him back to the night of the shooting, and he needed to leave the range.

Phase 2 (Introduction of EMDR Protocol)

During our second session, I talked to Corey about the benefits of EMDR. Corey expressed curiosity and willingness to partake in EMDR. Because of the severity of his symptoms, I received permission from the counseling center director to offer Corey two counseling sessions per week. He signed the treatment consent form, and I evaluated him for the appropriateness of EMDR. He was assessed for stability, acute presentations of suicidal/self-injurious behaviors, dissociative disorders, support systems and style of communication, medical con-

siderations, and readiness factors. I deemed him appropriate to receive EMDR treatment with the knowledge he needed to keep an open mind about talking to others about his stress rather than trying to bury it. I informed Corey of the seating arrangement, the stop signal, and the different modalities of achieving BLS.

BLS can be created through eye movements, tactile stimuli, or auditory stimuli. BLS occurs when the eyes follow an object across the visual field, horizontally, diagonally, or vertically. During BLS, the head is stationary while the eyes move in the client's preferred path. Corey chose a combination of eye movements and tactile BLS. The BLS options were practiced, and Corey reported feeling most comfortable with the light bar in a horizontal position. He further identified the full light bar at a speed of 3.1 and an intensity of 1.2 for the TheraTapper (2017). The TheraTapper is a handheld device that provides alternating BLS through vibrations. Corey reported that the combination of the physical vibrations in his hands and the light bar provided him with better awareness during the BLS.

Two different coping skills were implemented as grounding/calming strategies. Using the BLS of the eyes, Corey participated in the Safe Place/Keyword enhancement activity. He was walked through the Light Stream activity, which allows individuals to reduce their emotional reactions and bodily sensations to a feeling by using the visualization of a healing light attacking an area of mild discomfort.

I explained the adaptive information processing model in layman's terms and how EMDR works from a biological standpoint. I explained to Corey that during a traumatic event or stressful situation, the brain could sometimes pair an event with the emotional experience. Unfortunately, the brain is not designed to store information in this fashion, leading to a misfiling of the event in the brain that may contribute to anxiety, nightmares, flashbacks, and other psychological symptoms. The EMDR process helps the brain separate the emotional distress from the content of the event. Once an event is reprocessed and the emotional component has separated, the processing of the event is complete. The memories are then stored automatically by the brain through a process referred to as *reconsolidation* (Solomon & Shapiro, 2008).

The EMDR process can be overwhelming at times, and Corey was informed of a metaphor that could be used to help him notice what he was experiencing and to let it continue to be processed rather than to become fixated on it. This is often referred to as the *train metaphor*. The final component was to inform him of the stop signal; this was practiced, and he was encouraged to use it if he felt he could not continue processing at any time in the future.

Phase 3 (Assessment)

During the assessment phase, Session 3, Corey's narrative was obtained (refer to Table 1 for details). The BLS was reduced from a speed of 3.1 to 2.8 to ensure comfort and ease of tracking the lights. His narrative was an emotional process with moments of shallow/quick breathing, trembling vocal tone, shaking arms/hands/legs, and tears. Corey did not allow any of these reactions to deter him as he pushed through and shared his experience. He performed the internal mental search to identify specific targets of disturbances, the PoDs.

TABLE 1
Corey's Points of Distress (PoDs) Identified at
Bilateral Stimulation Narrative

Session Number and PoD	NC	PC	VOC Range	Emotion	SUD Range	Body Location
Session 4						
1. Shots being fired and sound of bullets hitting the cement	I am not safe	I am safe now	2 to 6	Fear, anxiety	9 to 2	Chest and head
Sessions 5–6						
2. Being hit in the back of the head with something	I am powerless	I am safe now	2 to 6	Scared	9 to 2	Stomach and gut
Sessions 6–7						
3. The sound of screams from people and the terrified looks on everyone's faces	I am in danger	I can handle it now	3 to 7	Fear	6 to 1	Chest
Session 7						
4. Being trapped in the hotel; someone screams, "They are here, the shooters are here!"	I am not safe	I am safe now	3 to 6	Fear	7 to 3	Chest
Session 8						
5. Poor man I left behind in the art gallery	I should have done something	I learned, and I have learned from it	4 to 6	Sadness	7 to 1	Head
6. Current day—always being afraid, always looking over my shoulder, afraid to go places	I am not safe	I am safe now	3 to 7	Fear	9 to 0	Chest and shoulders
Session 9						
6a. Safety within the house	I am not safe	I am safe	2 to 6	Fear/fight-or-flight response	9 to 3	Head, arms, shoulders, and chest
Sessions 10–12						
6b. Safety in public; this target morphed into a future-based target	I am not safe	I am safe, I can be safe	2 to 7	Fear	9 to 0	Head, arms, and chest
Session 13						
7. Turkey hunt	I am a bad person	I am a good person	4 to 7	I just feel shitty	5 to 0.5	Head and shoulders
Episode trauma						
Mass casualty experience		I am safe now	2 to 7		10 to 1	

Note. NC = Negative Cognition; PC = Positive Cognition; VOC range = Validity of Cognition from beginning to end; SUD range = Subjective Units of Distress from beginning to end.

PoDs can be obtained in any order of occurrence; during the PoD identification process, Corey laid out his PoDs in chronological order.

Corey was asked to further identify the supporting content of each PoD, which consisted of the Negative Cognition, Positive Cognition, VOC, emotional response in the current moment, SUD score, and the location in the body where the PoD was felt. Corey's PoDs, their complementary components, and the progression of change are included in Table 1.

Phase 4 (Desensitization)

The purpose of the desensitization phase is to reduce the amount of distress surrounding each PoD and to increase the person's VoC to an ecological value. Corey processed his most distressing PoD during his fourth session (refer to Table 1). This PoD was especially traumatic for Corey because it was a combination of fear, anxiety, and confusion. Within one session, Corey reduced his SUD and increased his VOC to ecological values of 2 and 6, respectively.

Corey processed his second PoD at his next appointment (refer to Table 1). During the BLS process, he experienced fright, gratefulness, and anger. He did not complete his second PoD because of time limitations, and he was informed reprocessing might continue between his sessions. Session 6 began with a check-in on how Corey had been doing, followed by a reassessment of his second PoD. The reassessment of the second PoD resulted in Corey noticing the vendors and the blank expressions on people's faces as he ran; this was used as the imagery, and BLS was initiated.

Corey began working on his third target and identified a sense of terror in his chest. To help him process these bodily emotions and sensations, I asked him to give them descriptors. This strategy is a component of EMDR called a *cognitive interweave*. A cognitive interweave allows the person to become more in tune with the experience and helps the individual to process the bodily and emotional components of trauma. Corey described the terror in his chest as having a round shape, white in color, a fuzzy texture, and without temperature. BLS occurred, and he reported panic and the sensation transitioned to his arms and forehead. Corey was asked to use his pointer and middle fingers like a pair and to find the very center of where he believed the panicked feeling had been radiating from in his head; this is another cognitive interweave referred to as the *two-finger approach*. BLS continued, and he reported feeling calm for three sets of BLS. Corey returned to his third PoD, and BLS continued; he continued processing the faces, concerns of what would happen if he heard screams again, and feelings of sadness.

It was at this time in the session that a door slammed right outside of my office while Corey was doing BLS; this noise immediately increased his panic. I encouraged Corey to process the sound of the door slamming with BLS. At the end of the set, he expressed concern for his other friends who were doing talk therapy; he wondered if EMDR would be good for them as well. He continued BLS and identified the many people who reached out to him after the shooting; because of time limitations, his session was brought to closure.

During the reevaluation portion at his seventh session, Corey reported a disturbing incident he wanted to address (refer to Table 1). This was discussed with him, and I suggested making the turkey hunt a PoD to address in his timeline; he was open and willing to do this. The reevaluation process continued, and when asked what he noticed about his third PoD, Corey smiled. He looked at me and stated he did not remember what the target was. After reminding him of his third PoD, he reported the PoD as something that he was now experiencing as just an image rather than reliving it (refer to Table

1). Corey processed his fourth PoD and his negative emotions until three sets of positive responses occurred. He was asked to return to his fourth PoD, and after several more BLS sets, he obtained two positive responses. Corey reported his SUD was still at a 3 and he was unsure whether it could get any lower for this target. Corey was in active BLS for 40 minutes and was able to reduce his SUD from a 7 to an ecological 3 and increased his VOC from a 3 to an ecological 6.

Corey processed his fifth PoD during his eighth session. In less than 27 minutes, he reduced his distress level from a 7 to a 1, increased his VOC from a 4 to a 6, and was no longer bothered by the scared man he left behind in the art gallery. Corey then addressed his sixth PoD (refer to Table 1). He continued through BLS and identified that it was impossible to get away from the news stories of the shootings. BLS continued, and Corey stated that he did not want to live a life full of fear. Because of time limitations, his session was brought to the closure phase.

The desensitization phase can be extremely overwhelming, provoke emotional responses, and produce overly active thinking for some individuals. Corey's sixth PoD continued to be processed in his unconscious, and I received a phone call early the following morning. Corey reported he was struggling with fear and only got 3 hours of sleep because of paranoid thoughts. Corey was given a walk-in appointment later that day, Session 9. Because of emotional reactions that occurred the previous night, I suggested breaking his sixth PoD into two separate targets: safety in his home and safety in public. It was also suggested that he start with safety within his house. Corey was open to this, and thus the components to the new PoD were identified (see Table 1).

Corey began the desensitization process with BLS and exhibited paranoid thoughts that people were following him, irrational thoughts of impending doom, and disturbing thoughts of having to shoot an intruder. Corey reported the fear was in his head and shoulders; several sets of BLS occurred, and Corey was having difficulty in processing the idea of being safe in his own home. I offered a cognitive interweave of asking him what his dad would tell him about how to be safe in his home. This interweave allowed further processing to occur. Corey continued to process his security, noting how nice people are and how happy he felt in the place where he resided. Because of time limitations, his session was brought to closure; he would be seen the following day as this was his regular appointment.

Session 10 began with a reassessment. Corey's BLS processing was initially slow and involved many images revolving around a dark bedroom, fear, shadows being cast under his doorway, and the struggle of having a gun under his bed. Several BLS sets later, he reported the image had transitioned, and his room was no longer dark but was now white and light. Two sets of BLS were performed to strengthen these positive images (refer to Table 1).

Corey had been able to reprocess his fear of safety within his own home, and it was during his 10th, 11th, and 12th sessions that Corey focused on being safe in public. Two sets into BLS, Corey had responses focused on a future event that he and his friends would be attending in the spring semester (this event will be referred to as SC hereinafter). Corey continued to process the

PoD with much of the focus being on the SC event. I asked Corey to return to his original PoD, and he stated that all he could think about was the SC event. He said this was causing him much anxiety and asked to make SC a PoD of its own (refer to Table 1). This alteration was agreed on, and from this point further, the PoD for this session was strictly the future-based SC event. BLS was initiated, and he noticed the large crowd, a sense of fear, and thoughts about security. His focus continued to be on the future imagined gunman standing on top of the RVs as rounds of ammunition were fired into the crowd of people returning to their campers. There was a noticeable change in his cognition and processing as he began examining the location of the future shooter versus his experience. As BLS continued, Corey acknowledged he was seeing the shooter's viewpoint to figure out why the shooter was doing it. He acknowledged feeling distressed about SC while at the same time feeling better than he had; the session was brought to closure.

Two weeks passed, and Corey was eager to begin the R-TEP process at his 13th session. BLS began, and he reported purposefully trying to imagine the shooter on top of the campers "and the first time the shooter, just poof, disappeared." Corey reported trying to envision it again, and "the shooter started handing out beers to everyone around him." (Refer to Table 1 for ending SUD and VOC scores.)

With the future based PoD having been addressed, I asked Corey to bring his attention back to his original sixth PoD (refer to Table 1). Corey stated he no longer thought that was an issue. He believed that once he was able to establish that he was safe in his own home, he no longer experienced any fear while in public. At this time, Corey asked to address his hunting experience. The commonalities between the turkeys and people running for their lives was creating a similar emotional response. Corey stated that he was amazed by EMDR and how the mind works, he spoke of initially comparing himself to the shooter at the music festival and then identified his remorse for hunting the birds. BLS continued with him thinking of the birds in a positive manner (refer to Table 1 for outcomes). Corey had addressed and obtained ecological scores for each PoD in his narrative; his session was brought to the closure phase because of time limitations, and he was informed he would continue his work by addressing the episode trauma at his next appointment.

Phase 5 (Installation)

Corey had completed all PoDs, and it was on this day that he addressed the entire mass casualty shooting (episode trauma) experience. Corey established his E-PC as "I am safe now." He completed 131 BLS sets and signaled that he had finished. I inquired as to what he had noticed, and Corey stated that most of the events were just memories. Corey identified that the initial running in the crowd after the gunfire started still caused him some emotional reaction. He was asked to focus on the initial running and the E-PC of "I am safe now." Four sets of BLS were conducted, and Corey reported that there was nothing there, and it was just a memory.

Corey identified struggling with the moment when someone yelled in the hotel and the fear that elicited. Corey was asked to keep that image in his mind and to pair it with his E-PC of “I am safe now.” Three sets of BLS occurred, and he reported feeling pretty good. I asked Corey to perform BLS and visualize the entire event from the day of the event to the present moment with his eyes open. Corey processed the events with 217 BLS passes of the light bar before signaling that he had reached the present moment. He was able to score his VOC for the entire event at a 7.

Phase 6/7 (Body Scan/Closure)

I then assisted Corey in completing a full body scan, starting at the top of his head and working through his entire body. Corey did not notice any bodily sensations associated with the episode trauma. Having reached an ecological SUD score of 1, a VOC of 7, and a clear body scan, Corey had successfully reprocessed his traumatic experience, and the session was brought to closure.

Phase 8 (Reevaluation)

One week after completing the R-TEP experience, Corey returned for a follow-up; he reported things had been going well. He had not experienced any thoughts regarding the shooting since his last session, and he was able to fall asleep easily with no nightmares and no issues regarding safety in his house nor out in public. Corey admitted that for a split second at his girlfriend’s graduation, he checked for exits but then did not have any other intrusive or negative thoughts about the situation. He stated the crowd and the noise did not bother him and he felt it was a positive experience. Corey reported feeling as though he was able to focus on his future and the positive things to come. It appeared Corey had been able to reestablish some normalcy in his life in terms of falling asleep, nightmares, connection, and support from others as well as no longer exhibiting fear with respect to future events.

To ensure Corey was continuing to maintain the present state, I asked him to return for another follow-up during the break between fall and spring semesters. Corey contacted me nearly a month after his final closure session of the R-TEP treatment surrounding the shooting. His mood was euthymic, his affect was bright, he was open in posture and communication, and his eye contact was good. Corey stated that life had been going well and spoke of socializing with friends and family and having had only one negative experience at home that he speculates was related to the shooting. He acknowledged, on reflecting on the situation, that his anxiety may have been heightened by an article he had read regarding a foiled shooting attempt at a hotel in Dallas. I spoke with Corey about the reality that he will still have moments in which he remembers his experience, because the goal of EMDR and R-TEP is not to dissolve the memories of our lives; instead, the goal is to decrease the distress that occurs when we have those memories. The difference between having emotional responses and experiencing distress surrounding an event was discussed.

Corey stated he did not have any other negative experiences. He reported that flying, driving, being in different cities, and even traveling alone had not increased his anxiety. It appeared that Corey had been able to complete R-TEP, and his negative thoughts, fears of safety, inability to sleep at night because of feelings of vulnerability, and decrease in social interactions had all been resolved. He continued to grow and interact in positive ways that align with how he wanted to live his life. Corey was encouraged to utilize counseling services again in the future if there was ever a time when he felt it was needed.

Discussion

When a gunman opened fire on concertgoers, 58 people were killed, 851 people were physically injured, and many people experienced negative psychological issues afterward. My client, Corey, was one of those people who experienced mental distress following the mass casualty shooting. This case study illustrates the usefulness of the R-TEP protocol within a college counseling center and the significant improvements that occurred because of this therapy modality.

R-TEP is different from the standard EMDR protocol in that it breaks a traumatic event into smaller individual traumas, PoDs. Each PoD has its Negative Cognition, Positive Cognition, distress level, emotion, and physical sensation/location. Breaking the entire trauma into individual PoDs allows a person to reprocess small yet highly distressing parts of the entire trauma in a more manageable way.

The impact that EMDR and R-TEP can have on the college population is reason enough to encourage and promote its use within college counseling centers. To offer EMDR services within their counseling centers, individuals must first be trained. There are EMDRIA-approved training organizations in many states (EMDRIA, n.d.), and Trauma Recovery/HAP provides many opportunities to be trained in EMDR at locations throughout the country (Trauma Recovery/HAP, n.d.). The financial component can create reservations about getting trained in EMDR, and yet being trained in EMDR has to be viewed as an investment into the counseling center as well as an enhancement of the counselor. The ability to offer EMDR at college counseling centers should be viewed as a service to the student body rather than an expense.

According to the most recent annual report from the Center for Collegiate Mental Health (2019), over the last several years college counseling centers have seen an increase in students who have had experiences of unwanted sexual contact/experiences; experiences of harassing, controlling, or abusive behaviors; and the experience of a traumatic event that left the student feeling intense fear, helplessness, or horror. More than 20% of the students who identified an unwanted sexual contact; an experience of harassing, controlling, or abusive behavior; or a traumatic event reported that the event had occurred within the last year (Center for Collegiate Mental Health, 2019).

The ability to offer treatment with EMDR and the R-TEP protocol is beneficial to mental health (Buydens, Wilensky, & Hensley, 2014) and the academic success

of students who have experienced negative events. Sikes and Sikes's (2003) article supports the benefits of EMDR use among the college population, and Rothbaum (1997) found that individuals who had been raped no longer had symptoms of PTSD after four sessions of EMDR. The literature surrounding the benefits of EMDR and R-TEP is substantial enough to promote its use in college counseling centers. As college counselors, our goal is to help students deal with psychological issues that interfere with their personal and academic lives, and yet many college counseling centers around the country are experiencing full caseloads, waiting lists, session limits, and pressure from higher levels of administration to care for the exponentially growing number of students who require mental health services (Auerbach et al., 2016; Theilking, 2017; Xiao et al., 2017).

The current case study demonstrates the success that students can experience from counselors' use of EMDR and R-TEP in a college counseling setting. In particular, this case study illustrates how effective and powerful R-TEP can be in assisting a student in transitioning from a nonfunctional stage of being to a fully functional one after a recent major traumatic event. Because of the effectiveness of EMDR, the addition of this treatment to counseling centers may assist in alleviating the increased demand for student counseling services.

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