Recent Traumatic Event Protocol

Sandy Browning
EMDR Europe Consultant
MA, RGN, Applied Psych
www.emdrwithinsight.com

HOW EARLY TO INTERVENE WITH EMDR?

The majority of people who experience a significant trauma will recover spontaneously; however there is often prolonged suffering and about 1/3 may be left with enduring distressing clinical or subclinical symptoms of PTSD and other psychiatric disorders (NICE, 2005)

DSM IV-RT

- **Acute Stress Disorder** (ASD) is defined as a disturbance occurring within 4 weeks of the traumatic event & lasting for a minimum of 2 days up to 4 weeks

- Distressing events are more diffuse - not so concentrated in the worst moments.

Timing of intervention

- Shalev's (2007) suggests that after one month if ASD signs & symptoms still present then should intervene.
- Bisson's (2006) view is to focus on high individuals with more symptoms 1 – 3 months post incident.
- Solomon (2008) advocates a longitudinal assessment of functioning or needs
- Shapiro & Laub (2008a) suggest intervening when there is excessive suffering and persistent disturbing symptoms, especially intrusive sensory images and sleep disturbance, or high risk is assessed, even a short time after the traumatic event.

Main issues in EEI

- Memory – in recent T nature of memory is fragmented & needs a different protocol.
- Therapeutic situation – atmosphere of emergency or urgency can lead to high arousal or distress; therefore Containment & Safety needs special attention
- Therapy contract; may be unclear & requires good practice guidelines

Guidelines for good practice in EEI

- Premature intervention - potential conflict with self healing ethos (pathologizing normal responses to abnormal situations)
- Prior history – usually 'normal' people in abnormal situations. However some have previous pathology, dysfunction or trauma.
- Specifically care should be taken regarding insufficient history intake, ego strength assessment, and insufficient rapport and preparation.

- Don’t open other clinical issues! This is not part of the clinical contract.

- Only go into other clinical issues that arise out of the trauma if this is not sufficient to promote adaptive processing.

Recent TRAUMATIC Event Protocol

- Past memories
- Present triggers
- Future template

Past Memories

- Obtain narrative history of event
- Each separate disturbing aspect or moment of memory
- Treat each separate aspect or moment as separate target with EMDR standard protocol and installation of PC

Separate ratings for specific events

- Heard the crack as they hit the Security man's helmet with an iron bar SUDS 8
- "Saw the balaclavas" SUDS 9
- Took my colleague away to open safe SUDS 7
- Shouting at me for dropping keys SUDS 9
- include important **sensory** aspects of the experience

- Target the most disturbing aspect or moment of memory
- Otherwise target events in chronological order.
- Target the remainder of the narrative in chronological order
- Have client visualise the entire sequence with eyes closed and reprocess it as any disturbance arises

- Client should have full association with material as it is being reprocessed.
- If disturbance, stop and using NC and PC process that part
- Repeat until entire event can be visualized from start to finish without emotional, cognitive, or somatic distress
- Have client visualise event from start to finish with eyes open, and install PC.
- Conclude with Body Scan.
- Only do Body Scan at end of processing of ALL of the targets.

Present Triggers

- Process present stimuli that may cause a startle response, nightmares, or other reminders of events

Future Template

- Create a future template
- For clients whose earlier history contains unresolved events that are associated with lack of safety and control, a longer treatment may be required.

Aspects of Emergency Room protocol

- Earliest intervention
- BLS primarily used for stabilising Acute Stress Response
- Grounding techniques (4 elements)
- “You’re alive, you’re safe now. You’re in the hospital; I am here for you”

When NOT to use EEI

- When patient is showing dissociative responses – hysterical paralysis, fugue like states
- When patient appears below border line intelligence
- Repetition of ‘you’re here, you’re safe now’ in quiet environment better

- Reverse the NC and the PC in order to affirm, enforce, enhance and embed issues of safety, control and recovery.
- It is TOO early for patient to say “I am in control” or “I will be OK”
- “I am safe” or “I am alive” are realistic

Installation

- Where are you now?
- Are you able to recognize that you are currently safe and that the dangerous event is over?
- Narrative of event – establishes proper sense of past, present, and future.

Body scan

- Not formally done but the ability to verbalize, cessation of shaking, and noticeable calming of body indicates ability to move towards closure
- It is normal for people to be agitated up to 2-3 days following a traumatic incident

EMD Protocol

- Most effective for processing intrusive sensory phenomena

STAGE 1:

- INTAKE information, appraisal & initial rapport
- try to get some idea of previous functioning, past traumas, support systems, contexts etc.
- Assess SMS (Severity, motivation, strengths) on 1-5 scale
- Minimum strength & motivation should be 3 when severity is high to do EEI

The decision to use EMD: guidelines

- what stage are they at in the recovery process?
- is the response normal/appropriate or unusual?
- simple/acute or complex PTSD?
- are previous traumas being re-activated?

STAGE 2: PREPARATION

- Normalize reactions
- Briefly explain EMDR
- Make an agreement for follow up

Further Preparation

- Use your **therapeutic presence** for support & establishing rapport

- Start with stabilization and grounding exercises such as The 4 elements, safe place & breathing

- Use a Metaphor if necessary to obtain distance & control

  ie. use a TV screen, remote control to turn down sound, drain the colour, etc.

- Plexi glass

Impact of Events Scale **Revised**

- If possible *& appropriate* administer (**Impact of Events Scale** for evaluation & follow-up purposes)
- takes 5 minutes & gives more information/ appraisal of extent of **Intrusion, Arousal & Avoidance** responses.

STAGE 3: ASSESSMENT

- Get client to tell the story- a narrative from the start *until they felt safe(er)* whilst doing BLS

- Moment by moment description together with inner appraisal (including thoughts and reactions) to assist in organizing the experience and priming the processing.

Don't forget!
Immediate aftermath of event

- Harrowing comments/events in hospital
- Non support or minimization by family/ colleagues
- Blame by colleagues/other survivors
- "What if's and if only's"

Caution!

- Be cautious about detailed description of gruesome details, assess for extent of dissociation and readiness to deal with intense affect.

Typical NC-PC themes:

- **RESPONSIBILITY: NC**: its my fault… I should have done something (else)..I could have avoided it
- **PC**: I did the best I could.. It was beyond my control…I am innocent

- **SAFETY: NC**: I am vulnerable… unsafe… ..in danger… .I'm going to die… ..
- **PC**: I am safe… .. I survived… ..

- **CONTROL: NC:** I am not in control… helpless /**PC:** I have some control…I have choices… Yes there are things I can't control -but I CAN (learn to) control how I respond.
- **SELF WORTH: NC:** I am bad… .I am inadequate… .I am not good enough.
- **PC:** I am a good person…I am okay as I am… the situation does not define my worth
- **THE EVENT: NC:** It's not supposed to happen /**PC:** It can happen.

Target most disturbing memory first

- use as much of the full protocol as is appropriate.

- be aware of likely NC's & PC's & *suggest them tentatively* when necessary.

If Affect high

- "speechless" terror and words are unavailable
- verbalization of an NC/PC may not be necessary or appropriate and correspondingly then no need for a VoC or for SUDs measures when the affect is evidently very high.

- 2 handed interweave from safe place to ‘high affect’ memory and back – short DAS in memory, longer slow DAS in safe place
- use grounding techniques
- Consider asking for a drawing or sketch for the target (especially with children)

TARGET & PROCESS

- **other disturbing moments** in chronological order (preferably) - again using as much of the full protocol as appropriate

"review the video" sequence **again (Google with DAS)**

- Ask C to "**review the whole video**" **sequence** again with eyes closed & pause (open eyes) at **residual anxious moments** then **PROCESS.**
- **Repeat** until the entire event can be visualized with significantly reduced distress
- (low observable or reported SUDs).

STAGE 5 INSTALLATION

- If not obtained previously select a spontaneous PC or ask for one now (if necessary suggest one tentatively- e.g. I survived… I am safe now

- **INSTALL PC** together with **visualizing the event from start to feeling safe**

Finish in a place of safety

Resource Connections

- Identify moments of strength, resourcefulness & control to install

- mental rehearsal for building self efficacy & future templates

Stage 6 Body Scan

- The body keeps the score

FOLLOW-UP COMMITMENT

- This can be overlooked in emergency situations but needs to be a responsible practice of EMDR

References:

- Shapiro, F., 2001 & 2006; in EMDR: Scripted Protocols Basics & Special Situations; Luber, M. Ed. Springer Publishing, NY, 2009
- Guedalia,J., Yoeli, F., EMDR Emergency Room & Wards Protocol (EMDR-ER) ibid.
- Shapiro, E., Laub, B., The Recent Traumatic Episode Protocol (R-TEP): An Integrative Protocol for Early EMDR Intervention (EEI), 2008a, 2008b, ibid.

Recent-Traumatic Event Protocol

- Shapiro & Laub (2008a, 2008b) suggest an ongoing trauma CONTINUUM
- The initial T experience & its aftermath is not yet CONSOLIDATED
- R-TEP incorporates & extends existing Early EMDR Intervention (EEI) protocols.
- Transition from EMD & RE to standard EMDR

Main features of R-TEP

1. Comprehensive approach -8 Phases
2. Integrative approach to EEI; incorporates EMD, RE, and EMDR protocols
3. Traumatic Episode; new trauma continuum time frame
4. Google search; mechanism for identifying multiple targets
5. Telescopic processing: expanding focus of regulation of chains of associations
6. Special attention to containment & safety
7. Maintaining standards of good practice
8. Theoretical underpinning

4 Elements

- Earth (feet)
- Air (Stomach, Chest)
- Water (Throat, Mouth)
- Fire (up through Head)

Earth

- Place both feet on ground, feel support of chair
- Notice 3 new things that you see
- Tell me what you hear*
- Tell me what you smell*

* (omit this if it brings attention to ongoing dangers ie. you are in the middle of a war zone)

Air

- Breathing for Strength, Balance, Centring
- Continue feeling the security of the ground
- Take 3-4 deeper, SLOWER breaths from your stomach to your chest
- Imagine letting go of some of the stress as you breathe out
- Direct your attention inward to your centre

Water

- Calm & controlled
- Switch on relaxation response
- Notice if you have saliva in your mouth
- Body's way of switching on parasympathetic nervous system
- Imagine tasting a lemon or something that would make your mouth 'water'

- Where do you feel it in your body?
- Does it feel good?
- Direct your attention to feeling good in your body and go with that (BLS)
- Install with brief, slow BLS or butterfly hugs

Fire

- Access a Safe place via your imagination
- Suggest somewhere safe and calm.
- ‘Where would you be?’
- As you think of it what do you:
- -see
- -hear
- -feel?

- Focus on your calm place, its sights, sounds, smells, and body sensations.
- Tell me what you are noticing
- Concentrate on where you feel those good sensations in your body and allow yourself to enjoy them. Now follow my fingers as you concentrate on those sensations
- Use 4 to 6 sets. ‘How do you feel now?’

Installation

- As you continue feeling the SECURITY NOW of your feet on the GROUND and feel CENTRED as you BREATHE in & out.
- Feel CALM & in CONTROL as you produce more & more SALIVA
- You can let the FIRE light your imagination and bring up the IMAGE of your CALM place. Do you have it?
- GO WITH THAT (BLS)