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).
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 times, the nature of memory is fragmented and 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 and 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 can 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 safer 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: it's 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
This can be overlooked in emergency situations but needs to be a responsible practice of EMDR.
References:

- Guedalia, J., Yoeli, F., EMDR Emergency Room & Wards Protocol (EMDR-ER) 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?’
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)