9

Emergency Response Procedure (ERP)

Gary Quinn

Introduction

The Emergency Response Procedure (ERP) was initially developed to help victims within hours of a terrorist attack, but can be applied in the minutes and hours following any trauma. Often, at that time, the patient has difficulty in orienting to the present after having experienced danger to self, family, or friends. When the clinician reorients a person to their present state of safety with ERP, he is assisting in a crucial task of adaptation by helping the victim's brain to understand that the danger has passed and the person is safe in the present.

The goal of ERP is to support patients in recognizing that they are "safe now" from the trauma that has just occurred. The incident is in the past and they can resume a present time orientation, as evidenced by calmer behavior and the ability to communicate verbally. If patients remain nonverbal, further intervention (including additional ERP) is immediately indicated.

The Emergency Response Procedure is versatile and has been utilized in the following locations and situations:

- Emergency room
- During initial hospitalization
- Immediate intervention in communal distress centers
- Critical incident scenes such as car accidents, earthquakes, natural or human-made disasters, death of a loved one, and in ambulances
- Abreaction during the initial history taking, prior to the Preparation Phase of EMDR
- During EMDR, and at other times when patients appear to be deeply fearful, it can be used as an interweave, to return them to a sense of present-time safety

Critical Incident Responses and ERP

Normally, after a critical incident, individuals present with a wide range of responses as reported in the Subjective Units of Disturbance (SUD) scale, where 0 = no disturbance and 10 = the highest disturbance possible. The individuals who arrive in emergency rooms/centers just after a critical incident usually report a SUDs of 7–10+/10. These victims are suffering greatly and are in need of immediate intervention to assist them in calming and deescalating.

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Marilyn Luber, PhD

ISBN: 9780826199218

Note: It is possible that this group later moves from an Acute Stress Reaction (ASR) to an Acute Stress Disorder (ASD). According to Briere and Scott (2006, p.166), 80% of those whose symptoms are initially severe enough to meet criteria for ASD will have PTSD six months later, while 60–70% will still have PTSD two years following the event.

Although it is possible that those patients with a 3–7/10 score could benefit from ERP, this group often is able to self-soothe. Therefore, more efficient use of the ERP practitioner's time will be with patients in a "highly agitated" state (7–10/10), and those who have moved into a "silent terror" (10+/10).

"Highly Agitated State:" When a patient is in a highly agitated state, her internal self-regulating system is not able to turn down the activation mechanisms, after the experience of danger has passed. When the sympathetic nervous system is activated, individuals will show symptoms including crying, screaming, yelling that they are not safe, increased arousal, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness, and an inability to execute necessary tasks. They are never silent. They are conspicuous to emergency staff because of their excessive noise. Not yet realizing they are safe from the event, these individuals are rarely able to present a coherent story and often act as though they remain in the middle of a dangerous situation.

In a sense, ERP jumpstarts the patient's self-regulatory system to reset and return to a state of calm that naturally occurs once the danger is over. Behavioral indicators of this relatively calmed state may include:

- Orienting to the present
- Interacting with first responders, family, and friends
- Inquiring as to family member whereabouts
- Talking about leaving the treatment location
- Discussing next steps and discharge arrangements
- Considering feasible living arrangements if needed

"Silent Terror" State: Beyond the "highly agitated state," patients may present with silent terror characterized by a dazed appearance, shaking and/or the inability to speak. Those experiencing silent terror have a 10+ score on the SUD scale. During a traumatic event, the sympathetic nervous system produces a normal response to danger of "fight or flight." However, when a person cannot fight or escape, the parasympathetic system kicks in and produces the "freeze" or silent terror response.

ERP is as effective for this group as it is for individuals presenting in a highly agitated state. Originally, when working with those in silent terror, this author believed that the ERP would not be helpful. These were the patients who were often ignored during an active rescue scene since they were silent. They would simply lie on the ground or on their stretchers and appear not to be suffering, much like patients immediately after surgery. Mistakenly, these patients were thought not to require immediate intervention.

While working on-site with patients, this author chanced using ERP with several individuals who were exhibiting silent terror. The true positive cognition, *"You are safe now,"* was employed and accompanied by bilateral stimulation. Later, when these patients were able to speak, they reported that although they did not seem to respond to what was said to them, many were actually enduring repeated flashbacks of the recently concluded traumatic event. They reported being terribly frightened and trapped in their inability to communicate with anyone about it.

Following administration of ERP, they began to speak and exhibit behaviors similar to those in the highly agitated group. This author continued saying, *"You are safe and now in the ER and you are okay,"* until their agitation calmed down. In subsequent debriefings, these patients came to realize that during their silent terror they were in a highly agitated state, but were incapable of telling anyone; thus, the term, silent terror.

ERP administered at these times seemed to re-engage the Adaptive Information Processing system. Once the recent danger was over, patients' AIP systems were unblocked and able to process the reality that they were "safe now." The activated system was able to return to normal.

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Emergency Response Procedure Script Notes

ERP Therapeutic Stance

ERP is a brief procedure, during which the therapist maintains an emphatic and confident position that resonates with the truth that *that* event is in the past and the patient is in the present. When using ERP, the therapist's stance should be the same described by Dr. Francine Shapiro (2001) for working with a patient during an abreaction:

> *The clinician should maintain a position of detached compassion in relation to the patient.* (p. 174)

She goes on to say:

> *To increase the patient's sense of safety, follow the "golden rule" of "Do unto others . . . " That is, the clinician should ask himself/herself what kind of support he would want if he were suddenly flooded with the emotions and physical sensations of childhood terror. The answer will probably reveal the importance of something that conveys an atmosphere of nurturing and trust and makes the clinician feel that it is safe to proceed. On the basis of this assumption, the patient should be continually reassured that the clinician is calm, caring, unsurprised by the content of the abreaction, supportive of its manifestations (regardless of how intensely expressed), and responsible for the safety of the situation.* (p. 175)

The fully present clinician and his recurrent supportive words have a strong grounding effect on patients after critical incidents. This results in patients reorienting back into the present time. The clinician's words, eye contact, and BLS are added elements that serve to anchor patients more solidly within that present time and safer location.

History-Taking

Patients who benefit from ERP are those who have difficulty telling a coherent history; patients in a state of silent terror cannot say anything at first while those in a highly agitated state have difficulty in telling very much history. If a patient cannot communicate, information about the incident is reported to the clinician by the ambulance or hospital staff. A more complete history regarding the immediate trauma can be done after the patient becomes verbal, once the ERP has been effective at establishing a present orientation (that the patient is safe from the recent dangerous event).

Assessment

In the Standard EMDR Protocol, the Assessment Phase allows patients to fully access their memory of the event on all levels. In the highly agitated state of Acute Stress Reaction (ASR), patients are very much in their internal world, already actively accessing the memory fully on the sensory, emotional, and body levels. Therefore, the formal Assessment Phase of EMDR is not necessary and the informal assessment proceeds as follows:

- The assumed initial negative cognition (NC): "I am in danger," or "My family or friends are in danger."
- The assumed initial positive cognition (PC): "I am/they are safe now from that event."
- The term *from that event* is added to give truth to the PC, allowing for ongoing danger (e.g., war, terrorism, natural disaster).
- Emotion is assumed to be high fear or terror.
- Subjective Units of Disturbance (SUD) is assumed to be at or close to 7–10+, where 0 is no disturbance and 10 is the worst disturbance imaginable.
- Body sensation: The therapist observes the body sensations such as muscle tension, catatonia, shaking uncontrollably, breathing rapidly, and so forth.

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EMDR and Positive Cognitions

In using positive cognitions in the face of critical incidents, this author learned that saying, "You are safe now," was not sufficient to help patients return to the present. "No, I am not safe; the missiles are still landing and the bombs are still exploding," was their frequent retort. When adding, however, the words, *". . . from the past event"* (as in "You are safe now, from the past event"), patients were able to calm down, reorient, and view this statement as a true positive cognition. The adding of, "It is over," reinforced, "You are safe now from that past event." A felt sense of present safety from that past event was highly instrumental in helping them to cope with/manage future events during which they could again be in danger.

Bilateral Stimulation (BLS)

The bilateral stimulation (BLS) used during the Desensitization Phase of ERP is based on the EMDR concept of utilizing dual attention. A patient is already accessing the past event as if it is happening now (first attention) and this is the cause of the distress. The patient, in the current reality of being in the emergency room (ER), is now safe (second attention) from the recent traumatic event. BLS is used in conjunction with the phrase, *"You are safe now from that past event."*

Type of BLS: Since tapping does not require active cooperation, it is used throughout the ERP processing.

Speed of BLS: Bilateral stimulation is offered at a rate as fast as the patient can follow or at a variable speed to keep patients in the present. Although in EMDR, patients may close their eyes when using tapping, it is most often helpful when using ERP to keep eyes open to secure a present orientation. After patients again become verbal or can begin to follow instructions, tapping accompanied by having them observe (the bilateral tapping) can be a powerful combination. It should be noted that patients who follow the tapping with their eyes will often be unable to keep up with the higher speed used when one BLS modality is used alone. The speed should thus be reduced to allow the patient to follow.

Sound (auditory) BLS is not often utilized as noise can trigger an aspect of the recent dangerous situation such as the sound of a missile landing or a crash. If eye movements or tapping are not available or useful, sound BLS can cautiously (and quietly) be attempted.

Ending Goals for ERP Patients

Patients who were initially verbal will be able to express their recognition of current safety and will demonstrate body language reflecting increased calm. Most patients will still have a degree of agitation. This can be seen as ecological for their current state.

The goals of ERP are reached when patients exhibit:

- Recognition of being in the present
- Recovery of the ability to communicate verbally
- Demonstration of body language suggesting a calmer state
- Ability to respond to the SUDs scale (SUDs = 3–5/10)

Moving Beyond Safety Concerns Into Responsibility Concerns

There are situations where establishing that a particular danger is in the past and that safety is in place will not be sufficient to bring down disturbance levels to a large degree below 3–5/10. At this stage, the patient is no longer in the "speechless terror" state (which may have been resolved by the ERP establishing current safety from that past event). Here, clients are most often verbal but can still be highly agitated. This often happens when there is a feeling of responsibility or lack of control and choices (i.e., following failed rescue attempts). In such cases, a focus on safety may not reduce distress during a desensitization or installation.

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The script below, under "Addressing Responsibility Concerns," may present a viable option to try when no progress has been made using safety as the target and when the patient is verbal and making comments such as "I should have done something," "I did something wrong," or "It's my fault."

Closure and Follow Up

This is a good time to ask for permission to contact patients at a later date to see how they are doing. In cases of emergency intervention with ongoing danger, a face-to-face follow-up session may not easily occur. However, at this point, the patient is verbal and you can request a phone number along with a friend or relative's phone number, and ask permission to contact them at an approximate time interval (week, month, etc.). Most patients are grateful and offer a positive response. Since you may not be able to contact them during times of ongoing danger, it is important not to say you *will,* but instead, you *may* call them.

According to the protocols of the emergency room, a patient is given a final medical exam before being released. In addition, the patient is given a fact sheet describing common physiological and emotional symptoms occurring within the first 48 to 72 hours of involvement in a traumatic incident. Examples may include flashbacks, difficulty sleeping, and increased sensitivity to loud noises. Also listed are unusually strong reactions such as increased anger and withdrawal. It is mentioned that most patients will usually experience steady improvement over the following month. Referral numbers are listed should further psychological treatment be desired.

Training and ERP

This procedure presumes clinician familiarity with the Standard EMDR Protocol from which it is adapted. Clinicians highly experienced in dealing with patients immediately after a traumatic event—who are not familiar with EMDR—may still benefit from this protocol.

Note: The ERP procedure has not received official sanction or endorsement from the EMDR Institute; however, it is in the early stages of being empirically investigated. To date, clinician and patient anecdotal reports are encouraging with an informal study (small N) by the author, suggesting that 75% of the patients who received treatment as usual (ie, no ERP) presented with PTSD two years post-trauma, compared to 25% who receiving ERP.

Emergency Response Procedure and Script

Phase 1: History Taking

Introduce yourself to the patient.

Say, *"I am* _____ (state your name). *What happened to you that brought you here now?"*

_____

_____

_____

Note: Usually this will be a brief report of what they have experienced if they are verbal. It helps establish a level of rapport and connection to the present. For those patients who do not respond, move to Phase 2: Preparation.

Phase 2: Preparation

Initial Preparation

If the patient is shaking uncontrollably or feeling overwhelmed, it is essential to normalize this behavior.

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Say, *"Your current shaking, rapid heartbeat, and breathing* _____ (or whatever signs the patient is showing) *is the body's normal healthy way of dealing with a dangerous situation."*

Preparation

Give a brief explanation describing EMDR.

Say, *"I will be using a procedure based on what your body and mind do naturally to deal with strong emotional experiences, which is similar to the natural state of dreaming when your eyes move rapidly back and forth. This can help you learn new things and be calm. It will also help you come back to the present. I am going to ask you to follow my fingers with your eyes, or with your permission, I am going to tap on your hands. If you would like me to stop, just raise your hand. Would that be okay with you?"*

If the patient does not respond add the following:

Say, *"I understand that you are extremely preoccupied with this event you have been through and are not talking now. I will assume you agree to do this procedure unless you say no or shake your head no."*

If there is any possibility of neck injury, do not ask them to shake their heads.

Phase 3: Assessment

The formal Assessment Phase of EMDR is *not* necessary and the informal assessment proceeds assuming the following: negative cognition (NC) = "I am in danger," or "My family or friends are in danger"; initial positive cognition (PC) = "I am/they are safe now *from that event*"; emotion = high fear or terror; Subjective Units of Disturbance = 7–10 + /10 (worst); body sensation = therapist's observation of patient's body sensations such as muscle tension, catatonia, shaking uncontrollably, breathing rapidly, and so forth.

Phase 4: Desensitization

Introduce Dual Attention and BLS

The way to use dual attention is by repeating the following:

Say, *"You are in the ER and safe now from that past event. That is over."*

In the case where the safety of family members is not known, say the following:

Say, *"That event is over. What has happened is over and in the past."*

Patients are directed to focus on the here and now of being safe in the hospital (or wherever they currently are) and away from the flashbacks of the incident despite their shaking bodies.

Say, *"You are in the hospital* (or wherever they are) *now and are safe from that past event. That is over."*

If there are flashbacks of the incident, use BLS (such as eye movements or hand tapping) together with the therapist's voice, and bring the patient back to the present and current reality of safety. See below.

Begin BLS. At first, there can be a re-experiencing of trauma followed by calming and the ability to communicate.

Say, *"I am going to ask you to follow my fingers with your eyes or, with your permission, I am going to tap on your hands."*

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Note: In the event a patient has a problem with the clinician touching her, a pen or any other neutral object can be used for light tapping.

Begin BLS.

Say, *"You are in the emergency room* (or wherever the patient is) *and you are safe. That event is over out there. You are safe here in the emergency room (or wherever the patient is). Focus on being in the* _____ (place the patient is presently located) *and safe, notice my being with you, listen to my voice, and feel my hands tapping on yours (or notice my hands moving)."*

Do BLS. Repeat the above statements during each set (as during abreaction) or approximately every 5 to 10 sets. BLS can be given in short or long sets or with varying speed during a set as is done during abreaction in EMDR. Stopping points can be when the patient appears to relax somewhat or starts to be verbal. Otherwise, a traditional set of 24 can be used.

Say, *"Take a breath. Let it go. What are you noticing?"*

_____

_____

If a patient does not verbally respond, say the following:

Say, *"Just notice what is happening,"* while doing more BLS and repeating the statement, *"You are safe now from that event that is over and you are in the* _____ (place where the person is located)*."*

Continue this until you see the patient's body calming and the patient is able to tell you what she is noticing.

Say, *"Take a breath. Let it go. What are you noticing?"*

_____

_____

For patients who present in a state of silent terror and are nonverbal, being able to communicate and recognize current safety can be seen as a stopping place. A completed SUD, in this situation, would be approximately 3–5/10, as inferred from body language or expressed by the patient.

Optional:

Note: In ERP, do not ask the patient to, "think of the incident."

Say *"On a scale from 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Phase 5: Installation

Formal EMDR installation is not done. Instead, assess the patient's awareness of current safety and location.

Say, *"Where are you now?"*

_____

_____

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When patients state the experience of being oriented and currently safe in the ER (or wherever they are), say the following:

Say, *"Are you able to recognize that you are currently safe and that the past, dangerous event is over?"*

When present safety recognition is not sufficient to allow closure, the difficulty may be a sense of lack of control/choice. If the patient says: *"But it's still dangerous and another attack/missile landing/earthquake can happen when I leave here,"* say the following:

Say, *"Yes, in the future there are many different things that can happen but what we have found is that letting yourself be in the present—here right now—can be helpful to figure out how to deal with those later situations even if it is 5 minutes from now. Can you let yourself realize that at this moment you are here and safe now with me? Because you are safe, right now. What happened is over. And later we can try to figure out a way to make sure you remain as safe as is possible, but now just notice that right now you are here and you are safe. All these other things can be dealt with much more easily when you can let yourself just be here safe right now."*

Note: Receiving a patient's engaged, affirmative response to the question regarding whether she can now recognize that she is safe is critical. That affirmation indicates that the patient has been able to reorient not only to "place" but also to "time." This means that the patient is aware that she is beyond the past threat/danger.

Sometimes a person needs to be reminded of real life solutions:

Say, *"What have you been told to do by the police if another siren goes off and you are in the car to keep you reasonably safe?"*

Say, "Go with that." Do BLS.

Once this has been accomplished, do not return the focus to the original incident. Instead, proceed to closure.

Addressing Responsibility Concerns (as Needed)

Should the client express comments that reflect self-blame, or a shift to the domain of responsibility, you can attempt to ask a clarifying question:

Say, *"Is there more about what just happened that you wish to tell me that can help us understand what may be keeping the distress from getting less? Feel free to tell me just what you are comfortable telling me now."*

Within the time frame that ERP treatment allows, it is very difficult to find a true, positive cognition when dealing with issues of responsibility. Therefore, after acknowledging the issue of responsibility, it is deferred for now. It will be dealt with by EMD or R-TEP (see below) or at a different time. In ERP we then return to "You are here now and that event is over" as a first step in the direction of dealing with any of the other issues or actions they may need to do later.

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Say,*"At times like this, it is common to try to find someone responsible for this terrible incident. You might blame yourself or blame others. But right now, whatever the reason that this happened, even though it is a horrible thing that happened, what has happened has occurred in the past and you are here right now. Being able to just let yourself know that you are here now and that this event is over is an important step for what needs to be done next. So please allow my tapping/hand movement to help you realize that you are here now—for whatever reason it happened—and you can be here this moment. Recognizing you are here now can help you deal with the other things you will need to do later. If this issue remains it can be addressed at a later time."*

At this point, most clients are at a reduced level of distress and you can move on to Closure.

Note: If the client still remains distressed, she may wish to talk more about the traumatic incident. If time permits, the following is recommended.

Narrative of Event

At this point, it is possible for patients to give a narrative of what they experienced. Do not push for details. This narrative is therapeutic. This can be helpful as it is using left-brain processing to establish the proper sense of past, present, and future.

Say, *"Please tell me what happened from just prior to the start of the event until now. Feel free to tell me just what you are comfortable relating."*

Very often, in telling the narrative, the client may remember details, temporarily forgotten, that could free them of a sense of responsibility. Or, they realize that they were more active than they remembered and therefore have a better sense of control than they originally thought. At other times, this narrative reveals another cognition that is an additional source of stress, such as a false sense of responsibility as in survival guilt, as mentioned above. Common negative cognitions are "I should have done something," or, "I did something wrong" (by not warning others or not saving other victims). In this case, EMD or R-TEP (Shapiro & Laub, 2009) may be utilized, if time permits. This may not be possible during mass trauma as many people are in need of immediate treatment.

If patients have not been able to calm down using ERP, other standard non-EMDR types of treatment such as medication can be utilized.

Phase 6: Body Scan

Body Scan is not formally done but the ability to verbalize, cessation of shaking, and noticeable calming of the body will indicate an ability to move to closure. It can be seen as normal for many people to be agitated up to two to three days following a traumatic incident.

Phase 7: Closure

Closure is done stating the following:

Say,*"It is common to have a reaction to what has happened to you. You might have flashbacks of what happened, difficulty sleeping, and a number of emotions such as distress, fear, or anger. You may notice that you are much more*

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jumpy and startle more easily by loud sounds or anything that reminds you of what happened. If you find these symptoms lasting longer than 2 to 3 days and not subsiding, this is not unusual, but we can help you to handle these reactions so that you will be calmer. Here are some numbers to call (give contact information), *if you would like more assistance. Do you have any questions?"*

_____

_____

If follow up is indicated, ask permission to contact them at a later date to see how they are doing.

Say, "Would it be ok for you to give me your phone number and a family or friend's phone number so that I may call to follow up and find out how you are?"

_____

_____

Say, *"I will try to follow up, but, if I can't, or if you need more assistance, please don't hesitate to call the numbers on the sheet for further help."*

Phase 8: Reevaluation

If you do have the opportunity for a follow up meeting, it is helpful to administer an Impact of Events scale to help assess if the patient needs further treatment and for use in research.

Acknowledgments

I would like to acknowledge Debby Zucker, EMDR Consultant, Clinical Social Worker, and Medic, who has utilized ERP during her emergency work with patients in ambulances. I would also like to thank Karen Lansing, LMFT, BCETS, Rosalie Thomas, PhD, and John Reiman, PhD, in the development of this chapter.

Most of all, I would like to thank Marilyn Luber, PhD, who tirelessly worked with me. Her vast knowledge as an EMDR expert and her ability to ask those perfect, insightful, and revealing questions, enabled me to discover and then articulate the elements that may be responsible for ERP's effectiveness.

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9A

SUMMARY SHEET:
Emergency Response Procedure (ERP)

Gary Quinn
SUMMARY SHEET BY MARILYN LUBER

Name:_____ Diagnosis:_____

Medications:_____

☑ Check when task is completed or response has changed or to indicate symptoms.

Note: This material is meant as a checklist for your response. Please keep in mind that it is only a reminder of different tasks that may or may not apply to your incident.

Phase 1: History Taking

History by Patient: _____ History from Hospital Staff: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Phase 2: Preparation

Physical Symptoms: _____

_____

Explanation of ERP ☐ Completed _____ Time

Agreement to do ERP ☐ Completed _____ Time

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Phase 3: Assessment

Assumed NC: "I am in danger."
Assumed PC: "I am safe NOW *from that event*."
Emotion: High fear or terror
SUD: 10/10
Body Sensation: (Therapist observation) _____

_____

Introduce Dual Attention and BLS: ☐ Completed _____ Time

Phase 4: Desensitization

Therapist: *"You are in the emergency room* (or wherever they are) *and you are safe. That event is over out there. You are safe here in the emergency room. Focus on being in the hospital and safe, notice my standing with you, listen to my voice, and feel my hands tapping on yours."*

Stop when patient appears to relax somewhat or starts to be verbal.

Note patient response: When patient who was in silent terror/nonverbal, exhibits shifts in body posture, can communicate and recognizes current safety with SUD around 3-5/10, this is a stopping place.

Change in body posture: ☐ Completed _____ Time
Starting to communicate: ☐ Completed _____ Time
Recognize current safety: ☐ Completed _____ Time
Degree of agitation SUD: _____/10

Phase 5: Installation (Formal Installation Not Done)

Oriented to location: ☐ Completed _____ Time
Recognition currently safe: ☐ Completed_____ Time
Recognition event is over: ☐ Completed _____ Time

If patient still feels threatened: Say, *"And yes, in the future there are many different things that can happen but what we have found is that letting yourself be in the present—here right now—can be helpful to figure out how to deal with those later situations even if it is 5 minutes from now. Can you let yourself realize that at this moment you are here and safe now with me? Because you are safe, right now. What happened is over. And later we can try to figure out a way to make sure you remain as safe as is possible, but now just notice that right now you are here and you are safe. All these other things can be dealt with much more easily when you can let yourself just be here safe right now."* ☐ Completed _____ Time

Responsibility concerns (as needed): Say,*"At times like this, it is common to try to find someone responsible for this terrible incident. You might blame yourself or blame others. But right now, whatever the reason that this happened, even though it is horrible, what has occurred is in the past and you are here right now. Being able to just let yourself know that you are here now and that this event is over is an important step for what needs to be done next. So, please allow my tapping/hand movement to help you realize that you are here now—for whatever reason it happened—and you can be here this moment. Recognizing you are here now can help you deal with the other things you will need to do later. If this issue remains, it can be addressed at a later time."*

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Narrative of Event (Optional): Use EMD or R-TEP, if time permits.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Target/Memory/Image: _____

_____

PC: _____

VoC: _____/7

NC: _____

Emotions: _____

SUD: _____/10

Sensation: _____

Phase 6: Body Scan (Formal Body Scan Not Done)

Can verbalize calming of body: ☐ Completed _____ Time

Phase 7: Closure

Therapist: *"It is common to have a reaction to what has happened to you. You might have flashbacks of what happened, difficulty sleeping, and a number of emotions such as distress, fear, or anger. You may notice that you are much more jumpy and startle more easily by loud sounds or anything that reminds you of what happened. If you find these symptoms lasting longer than 2 to 3 days and not subsiding, this is not unusual but we can help you to handle these reactions so that you will be calmer. Here are some numbers to call* _____ (give contact information), *if you would like more assistance. Do you have any questions?"*

Medical evaluation: ☐ Completed _____ Time
Given fact sheet on common symptoms: ☐ Completed _____ Time
Referral numbers as needed: ☐ Completed _____ Time

Phase 8: Reevaluation

Contact within the week: ☐ Completed _____ Date

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